DOCUMENT RESUME

ED 366 830	CE 065 763
TITLE	Arkansas Long Term Care Facility Nursing Assistant Training Curriculum. Revised.
INSTITUTION	Arkansas State Dept. of Human Services, Little Rock.
PUB DATE	Jul 92
NOTE	199p.
PUB TYPE	Guides - Classroom Use - Teaching Guides (For Teacher) (052)
EDRS PRICE	MF01/PC08 Plus Postage.
DESCRIPTORS	*Allied Health Occupations Education; Behavioral Objectives; Clinical Experience; Curriculum Guides; Instructional Materials; *Long Term Care; *Nurses Aides; Nursing Homes; *Personal Care Homes; Postsecondary Education; *Residential Care; Student Experience

ABSTRACT

This curriculum is designed for use in developing training programs for nursing assistants who provide nursing or nursing-related services to residents in long-term care (LTC) facilities. Implementation provisions provide a general overview of the basic requirements found in Arkansas' Nursing Assistant Training Program "Rules and Regulations." The course consists of a combination of classroom and clinical instruction. Part I requires a minimum of 16 hours of initial classroom instruction that include both theory instruction and skills demonstration in the classroom lab. Part II requires the completion of 59 hours of training consisting of theory, classroom lab, and clinical skills training that must include at least 16 hours of supervised practical training in a facility performing tasks on an individual under the direct supervision of the instructor. A section on qualifications of instructors follows. Part I contains five units: communication and interpersonal skills, infection prevention and control, safety and emergency procedures, promoting independence/respecting resident's rights, and introduction to resident care. Part II has four units: personal care skills, basic nursing skills, cognitive/behavioral/social, and basic restorative services. Each unit consists of objectives with related content. Appendixes include skills procedures, a glossary, common medical abbreviations, and Maslow's Hierarchy of Needs. Contains 22 references. (YLB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

CE

ED 366 830

Arkansas
Long Term Care Facility Nursing Assistant Training Curriculum

The Health Care Team
Governing Board
Administrator
Food Service
Physician and Consultants
Bookkeeping
Medical Record
Nursing RN LPN NA
OT. PT. RM.
Housekeeping
Maintenance
Volunteers
Restorative Care
Clergy
Rehabilitation
Community Support
Social Service
Laundry
Residents and Families

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it

☐ Minor changes have been made to improve reproduction quality

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

T Wingard

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

CE 065 763

PUB-023 (1/89)

BEST COPY AVAILABLE

STATE OF ARKANSAS

LONG TERM CARE FACILITY NURSING ASSISTANT TRAINING CURRICULUM

Written by
The Curriculum Committee for the
Nursing Assistant Training Program

July 1988
(Revised July 1992)

For information and implementation of this curriculum contact:

Office of Long Term Care
Division of Economic and Medical Services
Department of Human Services
Post Office Box 8059
Little Rock, Arkansas 72203
(501) 682-8487

TABLE OF CONTENTS

AUTHORITY . . . 3
PURPOSE/OBJECTIVE . . . 4
IMPLEMENTATION . . . 5
QUALIFICATIONS OF INSTRUCTORS . . . 8
PART I - (Theory/Lab) . . . 11
  Unit I - Communication and Interpersonal Skills . . . 13
  Unit II - Infection Prevention and Control . . . 19
  Unit III - Safety and Emergency Procedures (includes Heimlich) . . . 25
  Unit IV - Promoting Independence/Respecting Resident's Rights . . . 33
  Unit V - Introduction to Resident Care . . . 57
    1. Bedmaking . . . 57
    2. Meal Service . . . 58
    3. Caring for the Resident's Environment . . . 61
PART II - (Theory/Lab/Clinical) . . . 63
  Unit VI - Personal Care Skills . . . 65
    1. Bathing . . . 65
    2. Grooming . . . 66
      A. Oral Hygiene . . . 66
      B. Hair Care . . . 68
      C. Nail Care . . . 70
      D. Shaving . . . 70
      E. Foot Care . . . 70
    3. Dressing . . . 71
    4. Toileting/Elimination . . . 72
    5. Feeding . . . 81
    6. Hydration . . . 83
    7. Skin Care . . . 85
    8. Transfer/Positioning/Turning . . . 88
    9. Occupied Bed . . . 93
    10. Restraints . . . 94
  Unit VII - Basic Nursing Skills . . . 97
    1. Vital Signs . . . 97
      A. Temperature . . . 97
      B. Pulse . . . 101
      C. Respiration . . . 102
      D. Blood Pressure . . . 103
      E. Height/Weight . . . 105
    2. Recognizing and Reporting Abnormal Changes . . . 106
    3. Deatn and Dying . . . 112
    4. Admission/Transfer/Discharge . . . 114
  Unit VIII - Cognitive/Behavioral/Social . . . 117
  Unit IX - Basic Restorative Services . . . 137
APPENDIX: . . . 143
  Skills Procedures . . . 145
  Glossary . . . 182
  Common Medical Abbreviations . . . 191
  Maslow's Heirarchy of Needs . . . 192
  References . . . 193
  Curriculum Committee . . . 196
  Acknowledgements . . . 202

TO THE NURSING ASSISTANT
AND THE RESIDENTS OF LONG TERM CARE FACILITIES

May we never speak to deceive old people
    or listen to betray them;

May we have the wit and wisdom to seek
    the truth and the fortitude to stand
    up for their basic human rights;

May we give recognition for past experiences
    and memories;

May we show dignity and self respect
    for the future;

May we minister the highest quality of
    health care to each individual person;

May we seek to understand the last
    period of life for which the first
    was made.

The Curriculum Committee

AUTHORITY

The following curriculum and regulations for the Long Term Care Facility Nursing Assistant Training Program are duly adopted and promulgated by the Department of Human Services pursuant to Arkansas Code §20-10-701 et seq.

This initiative is pursuant to the Federal mandates of Public Law 100-203 (the Nursing Home Reform Act, Subtitle C of the Omnibus Budget and Reconciliation Act of 1987 and technical amendments of OBRA 1989 and 1990) concerning the training and competency evaluation of nursing assistants employed in long term care facilities.

The Federal Omnibus Budget Reconciliation Act of 1987, 1989, and 1990 (OBRA) and regulations issued by the Department of Health and Human Services - Health Care Financing Administration (HCFA) established the minimum requirements for nursing assistant training and competency evaluation programs in Section 1819(a) - (f) and 1919(a) - (f) of the Social Security Act.

PURPOSE

The Arkansas LTCF Nursing Assistant Training Curriculum must be used to develop training programs for individuals who provide nursing or nursing-related services to residents in long term care facilities and who are not licensed health professionals or volunteers who provide services without monetary compensations.

These requirements are designed to assist long term care facilities and other educational institutions with training and competency programs for nursing assistants. The objective of the Nursing Assistant Training Program is the provision of quality services to residents by nursing assistants who are able to:

1. perform uncomplicated nursing procedures and to assist licensed practical nurses or registered nurses in direct resident care;
2. form a relationship, communicate and interact competently on a one-to-one basis with the residents as part of the team implementing resident care objectives;
3. demonstrate sensitivity to residents' emotional, social, and mental health needs through skillful, directed interactions;
4. assist residents in attaining and maintaining functional independence;
5. exhibit behavior in support and promotion of residents' rights;
6. demonstrate observational and documented skills needed in support of the assessment of residents' health, physical condition and well-being.

The training program must teach the attitudes and behaviors (which reflect attitudes) which promote the healthy functioning of residents both physically and emotionally, and focus on the restoration and maintenance of the resident in as independent as possible status. These attitudes and behaviors of staff are demonstrable in the day-to-day care environment in the facility.

IMPLEMENTATION

A. General Provisions

The following implementation provisions represent a general overview of the basic requirements found in the Nursing Assistant Training Program "Rules and Regulations" issued (under separate cover) by the Office of Long Term Care. Please refer to the official "Rules and Regulations" for complete comprehensive program requirements.

This curriculum is to be used as a guide for conducting training in both facility and non-facility programs. Each facility or entity that desires to offer a program must file an Application for Program Approval form prescribed by the Department of Human Services, Office of Long Term Care.

These guidelines essentially provide the outline for each training program and can be enhanced by the inclusion of current information to keep training relevant to changing needs. The content provides fundamental information and leaves open the opportunity for an instructor to function as necessary in response to perceived student requirements. These guidelines state the measurable performance criteria which serve as the basis for the state competency evaluation test.

It is important to recognize that the curriculum guidelines identify the limitations of the LTCF nursing assistants' direct care responsibilities.

Upon successful completion of the required training, the trainee must pass the state competency evaluation test administered by the Department of Human Services. An individual must complete the state competency evaluation test within 12 months of graduation from a training program or retraining will be required.

B. Implementation Requirements

Each course shall consist of a combination of classroom and clinical instruction. The requirement for state certification will be minimum of 75 hours of training with a balance between theory instruction and skills training. Skills training is composed of both skills demonstration in the classroom lab and skills performance in the clinical area with residents in a long term care facility. The clinical site must be a long term care facility which has not been disqualified by the Office of Long Term Care.

A minimum of 16 hours initial classroom instruction is required in Part I. This will include both theory instruction and skills demonstration in the classroom lab. During Part I the trainee is not allowed on the floor as part of a facility's staffing pattern. After completion of Part I, a trainee may be used in a facility's staffing pattern but only assigned to duties for which they have demonstrated competency. Documentation of acceptable performance of all skills and duties shall be on file with the Primary Instructor.

Part II requires the completion of the remaining 59 hours of training consisting of theory, classroom lab and clinical skills training. Clinical skills training must include at least 16 hours of supervised practical training in a facility performing tasks on an individual under the direct supervision of the instructor.

> NOTE: Each Unit in Part II has the required number of hours specified, accounting for classroom activity (theory and lab) and clinical on the floor. Each sub-unit has the number of hours specified for the classroom activity (theory/lab) but not clinical. Clinical training shall take place at the end of each Unit, with the students performing tasks/skills under the supervision of the instructor.

In programs that are facility-based, who wish to use student trainees in staffing while in training following completion of Part I, a minimum of ten (10) hours per week must be spent in the training program until completed. This provides for the completion of the training program allowing time for students to challenge and successfully pass the competency evaluation test within a four (4) month limit.

Each program shall issue to each trainee, upon successful completion of the program, a written statement in the form of a certificate of completion, which shall include the program's name, the student's name and social security number, the date of completion and the signature of the Primary Instructor. Such certificate, or copies thereof, shall serve as evidence of successful completion of a training program in order to be eligible to take the state certification/competency test.

C. Classroom Facilities & Resources

The nursing assistant training program shall require the provision of physical facilities as follows:

- Comfortable temperatures.

- Clean and safe conditions.

- Adequate lighting.

- Adequate space to accommodate all students.

- All equipment needed, including audio-visual equipment and that needed for simulating resident care.

The physical facilities including classrooms, laboratories, conference space, library and educational materials shall be adequate to meet the needs of the program, the number of trainees, and the instructional staff. Suggested training material/resources may include (but not be limited to) a blackboard, flipchart, projector/screen, VCR, interactive video machine, anatomical chart, mannequin, bed, lavoratory/sink, etc.

The Department will not require or endorse any one textbook or other material such as video-tapes, films, etc. There are several textbooks, video-tapes, etc. on the market and each facility or school will have the choice in selecting their materials. The curriculum guide is to be used in identifying the information to be taught in order that each program will know the objectives and procedures expected to be communicated to the nursing assistant trainee in order for them to pass the state competency evaluation.

QUALIFICATIONS OF INSTRUCTORS

A. Primary Instructor (PI)

The training of nursing assistants must be performed by or under the general supervision of a registered nurse (licensed in Arkansas) who possesses a minimum of two (2) years of nursing experience, at least one (1) year of which must be in the provision of long-term care facility services.

In addition to the above nursing experience requirements, instructors of nursing assistants must have at least one of the following;

- have completed a course in teaching adults (train-the-trainer workshop, etc.)
- have experience in teaching adults
- have experience in supervising nursing assistants.

In a facility-based program, the training of nursing assistants may be performed under the general supervision of the Director of Nursing (DON), who is prohibited from performing the actual training (unless replacement DON coverage is provided).

An individual who will be the Primary Instructor and meets the above criteria may submit the application for program approval identifying their qualifications to teach. This must include nursing experience and/or certificate of attendance in an instructor workshop.

B. Primary Instructor Responsibilities

There must be one, and only one, Primary Instructor for each course. All questions and correspondence referring to the course will be directed to this person. The PI should participate in the planning of each lesson/teaching module - including clinical instruction - whether or not the PI teaches the lesson.

The Primary Instructor of a nursing assistant training program shall be responsible for ensuring that the following requirements are met:

(1) Course objectives are accomplished.

(2) Only persons having appropriate skills and knowledge are selected to conduct any part of the training.

(3) The provision of direct individual care to residents by a trainee is limited to appropriately supervised clinical experience.

(4) Each trainee demonstrates competence in clinical skills and fundamental principals of resident care. The task performance record (skills check-off) must be performed by the Primary Instructor who must sign or initial all final skills check-off records.

(5) Records are kept to verify the participation and performance of each trainee in each phase of the training program. The satisfactory completion of the training program by each trainee shall be attested on each trainee's record.

(6) Each trainee is issued a certificate of completion which includes at least the name of the program, the date of issuance, the trainee's name and social security number and the signature of the Primary Instructor.

C. Additional Instructors/Trainers

Instructors may use other qualified resource personnel from the health field as guest instructors in the program to meet the objectives for a specific unit. Examples are pharmacists, dietitians, social workers, sanitarians, advocates, gerontologists, nursing home administrators, etc. They should have a minimum of one (1) year experience in their respective fields.

Licensed Practical Nurses (LPN's) may be used to provide classroom and skills training and supervision. They must be under the general supervision of the Primary Instructor, and have a minimum of one (1) year of long term care experience. (All final skills check-off reviews must be performed by the Primary Instructor.)

The Application of Program Approval shall be used to identify each additional instructor/trainer and their qualifications to teach.

PART I

CLASSROOM TRAINING - 16 HOURS
(Theory and Classroom Lab)

NOTE: The trainee can not provide any direct nursing services to residents until completion of Part I.

Unit I
Communication and Interpersonal Skills
(2 hours theory/classroom lab)

OBJECTIVE	CONTENT
Discuss the role of the nursing assistant as a member of the health care team.	1. The Health Care Team 1.1 The nursing assistant is a member of The Health Care Team. 1.2 See diagram on cover.
List desirable attitudes and actions which will provide successful job performance for the nursing assistant.	2. Attitudes/Actions Which Lead to Successful Performance of a Nursing Assistant 2.1 Dependability: a. Reporting to work on time. b. Minimum absences. c. Keeping promises. d. Completing assigned tasks promptly and quietly. e. Performing tasks you know should be done without being told. 2.2 Accuracy in following instructions. 2.3 Sensitive to feelings and needs of others.
List desirable personal grooming habits for the nursing assistant.	2.4 Personal appearance: a. Appropriate, neat, clean clothing. b. Comfortable, neat, clean shoes of an appropriate style. c. Personal hygiene. d. Name tag. e. Watch. f. Ink pen. 2.5 Personal health: a. Good nutrition. b. Adequate sleep and rest. c. Good emotional health. d. How to handle stress.
Define the goals of a long term care facility.	3. Goals 3.1 Goals of a long term care facility: a. Provide a safe environment. b. Maintain and promote health. c. Provide a satisfying social environment. 3.2 Goals of the nursing assistant: a. Learn to set daily goals consistent with the short

Unit I (contd.)

OBJECTIVE	CONTENT
	and long term goals of the Plan of Care. b. Learn to set short and long term personal, job and career goals.
	4. Communication
Define communication.	4.1 Definition - The sending and receiving of messages.
Identify types of communication.	4.2 Types of communication: a. Nonverbal - Sending a message without words by - (1) Body position & gesture. (2) Facial expression. (3) Touch. (4) Tone of voice. b. Verbal - Sending a message through talking or writing.
List attitudes which promote communication.	4.3 Attitudes which promote communication: a. Courtesy. b. Keeping emotions under control. c. Empathy.
	4.4 Behavior which enhances communication between the nursing assistant and the residents: a. Provide opportunity for resident to express thoughts and feelings - (1) Listen to resident's comments. (2) Allow enough time for communication. (3) Allow enough time for silent communication. b. Observe nonverbal behavior during interaction - (1) Body position. (2) Facial expression. (3) Gestures. c. Listen carefully to expressed thoughts and feelings and to tone of voice. d. Encourage focus on resident concerns - (1) Don't criticize other staff.

Unit I (contd.)

OBJECTIVE	CONTENT
	(2) Be responsive to resident's needs. (3) Self understanding on part of nursing assistant.
	4.5 Communicating with resident's friends and family:
	a. Factors which promote good interpersonal relationships with resident's family and friends - (1) Kindness. (2) Patience. (3) Empathy. (4) Listening to family members. (5) Not interfering in private family business.
	b. Restrictions in information given to families - (1) One designated individual (usually the charge nurse) communicates such information as diagnosis, doctor's orders, medical status. (2) Maintain confidentiality in communicating with family.
Identify basic factors which may block communication between resident, family and staff.	c. Inappropriate behavior or communication between resident, family, and staff may be due to - (1) Family's feelings of guilt or grief at institutionalizing the resident. (2) Resident's feelings of anger, guilt at being institutionalized. (3) Concerns about money, pain, the future, separation from loved ones, etc.
	4.6 Information the nursing assistant shall report to charge nurse: a. Information about a resident that could result in harm.

OBJECTIVE	CONTENT
	b. Any change in resident's behavior or physical condition. 4.7 Using mechanical devices to promote communication:
Identify steps for answering resident's call signal.	a. Answering call signals - (1) Answer as soon as call light goes on. (2) Turn off call signal upon entering the resident's room. (3) When finished helping the resident, replace call signal where it can be reached (OLTC Regulation). b. Techniques for using phone or intercom - (1) Identify your area. (2) Identify yourself and your position. (3) Speak slowly and clearly. (4) When taking a message write it down and who it is from. 4.8 Communicating and assisting the vision impaired resident:
List steps to communicate with the vision impaired resident.	a. Identify yourself when approaching the resident and when you are leaving. b. Recognize the use of light touch on the arm or shoulder to get attention. c. Objects (furniture, personal items, etc.) are not to be moved or changed. d. Use descriptions when you talk about - (1) Color. (2) Size. (3) Texture. (4) Location. e. Serve as a sighted guide - (1) Offer resident your elbow. (2) Allow resident to hold your arm. (3) Tell resident when approaching steps/stairs.

Unit I (contd.)

OBJECTIVE	CONTENT
	f. If assisting resident in seating is requested, place resident's hand on seat of chair.
List steps communicating with the hearing impaired resident.	4.9 Communicating with the hearing impaired: a. Place yourself where the resident can see you and establish eye contact and move closer to the resident if necessary. b. Speak slowly. c. Speak clearly using a moderately loud voice, avoid shouting. d. Sit or stand with the light above or toward you. e. Use body language as needed to emphasize your message. f. Be patient, friendly, kind, and do not patronize.
Describe techniques for communicating with the resident who cannot speak.	4.10 Communicating with the resident who cannot speak or has difficulty speaking: a. Agree upon meaning of signals to be used (i.e. one for yes, two for no) - (1) Eye blinking. (2) Hand squeezes. (3) Head nodding. b. Use communication flash cards/board. c. Verify resident's communication. d. Share with other team members the methods used to communicate with the resident.
	4.11 Communicating with a demanding/angry resident: a. Be courteous. b. Be in control of your emotions. c. Be tactful. d. Be a good listener. e. Be a careful, nonjudgemental observer.
	4.12 NEVER act or appear condescending to a resident:

OBJECTIVE	CONTENT
	a. DO NOT "talk down". b. DO NOT use "baby talk". c. Address the resident by name. d. Treat the resident as an adult.
Define Confidentiality.	4.13 Respecting confidentiality in communication: a. Confidentiality means keeping residents personal information private.
List examples of appropriate and inappropriate use of resident information.	b. DO NOT discuss personal information with - (1) Another resident. (2) Relatives of friends of the relative. (3) Representatives of the news media. (4) Fellow workers, except when in conference. (5) One's own family or friends.

Unit II
Infection Prevention and Control
(2 hours theory/classroom lab)

OBJECTIVE	CONTENT
	1. Infection Control
Identify reasons why infection prevention and control is important.	1.1 Practices which help reduce the number and hinder the transfer of disease producing microorganisms from one person to another, or from one place to another may be called infection control.
Identify practices which hinder the spread of infection.	1.2 Infection control practices are important because: a. Microorganisms are always present in the environment. b. Some of these microorganisms can cause disease (pathogens). c. Elderly people and individuals with chronic disease are often more susceptible to pathogens. d. Reducing the number of microorganisms and hindering their transfer increases the safety of the environment.
Name conditions needed for microorganisms growth.	1.3 Conditions needed for growth of microorganisms: a. Nourishment. b. Moisture. c. Usually warm temperature. d. Usually air. e. Usually darkness.
List ways microorganisms spread.	1.4 Ways microorganisms spread: a. Direct contact with a person who carries it or has the infection. b. Indirect contact - Touching objects contaminated by a person with infection, taking in food or other substances which have been contaminated.
Name the single most important infection control practice.	1.5 Practices which hinder the spread of infection: a. Infection control practices Washing your hands WASHING YOUR HANDS!!!

Unit II (contd.)

OBJECTIVE	CONTENT
	Washing your hands is the single most important control practice.
List infection control practices which hinder the spread of infection.	b. Cleaning the resident's unit. c. Handling bed linen correctly. d. Disposing of contaminated articles correctly. e. Cleanliness of self and resident.
	2. Handwashing 2.1 Reasons for good handwashing: a. Everything you touch has germs on it. b. In your work you use your hands constantly. c. Our hands carry germs from resident to resident and from resident to you. Washing your hands will help prevent this transfer of germs. d. Handwashing is the first line of defense against spreading microorganisms.
Identify and demonstrate measures of handwashing.	2.2 Handwashing routine: (refer to procedure #9 in the Appendix) a. Wash your hands before and after contact with each resident (OLTC Regulation). b. Use soap dispenser rather than bar soap if available. c. Use enough soap to produce adequate lather. d. Vigorous rubbing over surface of hands helps remove microorganisms. e. Hold your hands lower than your elbows while washing. f. Rinse from the clean to dirty. Elbows (clean) to finger tips (dirty). g. Rinse your hands well after washing and dry thoroughly with paper towel. h. The water faucet is always

OBJECTIVE	CONTENT
	considered contaminated. Use paper towels to turn faucet off.
	3. Universal Precautions for Blood and Body Fluids 3.1 Objectives:
List three objectives of universal precautions for blood and body fluids.	a. To minimize contact with blood and body fluids of ALL residents treated by the facility. b. To minimize the likelihood of transmission of specific blood borne organisms such as Hepatitis B and Human Immunodeficiency Virus (HIV). c. To help achieve a consistent application of infection control principle.
List and describe universal precautions to be used when caring for a resident with potentially infectious conditions.	3.2 Universal Precautions: a. The blood and body fluids of all residents regardless of their diagnosis or isolation precaution status shall be considered POTENTIALLY INFECTIOUS. b. These universal precautions shall include but are not limited to the following procedures - (1) Hands should always be washed before and after contact with residents. Hands should be washed even when gloves have been used. If hands come in contact with blood, body fluids or human tissue, they should be immediately washed with soap and water. (2) Gloves should be worn when contact with blood, body fluid, tissues or contaminated surfaces are anticipated. Gloves shall be changed after

OBJECTIVE

CONTENT

each resident contact. Gloves should be readily available.

(3) Mask eye protection and other protective clothing should be worn during procedures which are likely to generate splattering of body fluids.

(4) To minimize the need for emergency mouth-to-mouth resuscitation bags, or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictible.

(5) Blood spills, urine, feces and sputum shall be cleaned up promptly with a disinfectant solution.

(6) All specimens should be put in a well constructed container with a secure lid to prevent leaking during transport. Contamination of the outside of the container shall be avoided during collection.

(7) There are disease specific isolation precautions. The charge nurse will instruct the nursing assistant on them at the time of need.

State reasons for using isolation practices.

4. Isolation
  4.1 Residents with certain types of infections may be separated from other residents to:
    a. Keep the germs that cause

Unit II (contd.)

OBJECTIVE	CONTENT
	disease isolated in the resident's unit where they can be destroyed or specially handled. b. Protect persons outside the resident's room from contact with germs. 4.2 Terms associated with isolation: a. Contaminated - any article that is in contact with the resident in the isolation unit is considered contaminated (dirty with germs). b. Clean - means uncontaminated; refers to all articles and places that have not been contaminated by contact with pathogens. 4.3 Methods of isolation: a. There are disease specific isolation methods and the charge nurse will give instructions on use when necessary to implement them. 4.4 Isolation techniques: (refer to procedure #45 in the Appendix) a. The following precautions may be used -
Identify and demonstrate measures of isolation: (1) Preparing the unit. (2) Isolation handwashing. (3) Gowning/gloving/masking.	(1) Preparing the unit - caution signs will be placed on the door of the isolation room as an alert (OLTC Regulation). (2) Disposable dishes and utensils will be provided at meals. (3) Double bagging linen and trash before carrying out of room. (4) Gowns, gloves and/or masks will be worn: -Gowns are indicated if soiling of clothes is likely or to prevent cross contamination of clothing. (5) Special handwashing techniques.

Unit III
Safety and Emergency Procedures
(4 hours theory/classroom lab)

OBJECTIVE	CONTENT
Define body mechanics as it applies to the nursing assistant.	1. Employee Safety 1.1 Body Mechanics: a. Definition - Special way of standing and moving one's body. The term body mechanics is commonly used to describe the body movements by the staff when they move residents and/or objects.
Identify the purpose of good body mechanics.	b. Purpose - (1) To make the best use of strength and avoid fatigue. By using good body mechanics you can prevent injuries, eg., back strain and/or torn ligaments/muscles. (2) Good body mechanics on the part of the nursing assistant decreases the chance of injury.
Identify and demonstrate rules of body mechanics.	c. General Rules - (1) Use as many large muscles or groups of large muscles as possible: -Use both hands rather than one hand to pick up a heavy object. -Use the large muscles in your legs when picking up a heavy object instead of smaller back muscles. -Squat down, bending your knees. Keep your back straight and raise up, using your leg muscles, NEVER bend over at the waist to lift heavy objects. (2) Always stand erect. Good posture is essential to good body mechanics.

OBJECTIVE	CONTENT
	(3) When lifting, your feet should be approximately with the width of your shoulders, distance apart (at least 12 inches). This gives a broad base of support. (4) Be as close as possible to what you are lifting or moving. Don't reach and try to lift or move an object. (5) Use your arms to support the object. The muscles of the legs actually do the job of lifting NOT the muscles of your back. (6) When doing work, always work with the direction of your efforts not against them. Avoid twisting your body as much as possible. (7) If you think the object is too heavy to lift, then get help. Don't try to lift it alone. (8) Always move residents who can not assist you by two people. It is easier on the resident physically and prevents you from being injured. (9) Lift smoothly to avoid strain. Always count "one, two, three" with the person you are working with. Work in unison. Do this with the resident. (10) When changing the direction of your movements: -pivot. -turn with short steps. -turn your whole body.

OBJECTIVE	CONTENT
	2. Resident Safety
Identify reasons for safety precautions for the residents.	2.1 Reasons for safety precautions for the elderly; increased chance of accidents due to: a. Mental confusion. b. Impaired mobility. c. Diminished senses (sight, hearing, touch, taste, smell).
Identify the basic safety steps the nursing assistant must take to prevent falls.	2.2 Safety precautions the nursing assistant should take to help residents: a. Prevent falls - (1) Have bed rails up as needed and bed in lowest position. (2) Resident should wear shoes or slippers with non-skid soles. (3) Have shoe laces tied. (4) Avoid long gowns or robes which may trip resident. (5) Throw rugs should not be used. (6) All liquid spills should be wiped dry immediately. (7) Encourage use of hand rails. (8) Canes and walkers should have good non-slip tips. (9) Use caution when skin and bath oils are used because it makes people and tubs slippery. (10) Assistance items such as shower chair and raised toilet seat may prevent falls for residents with limited mobility. (11) Resident should be instructed to ring the call bell for assistance rather than climbing over bed rails.

OBJECTIVE	CONTENT
Identify the basic steps the nursing assistant must take to prevent burns.	b. Prevent burns - (1) Assist a confused person when he is given hot liquids to drink. (2) Bath water must be checked to insure it is a safe temperature before the resident gets in the tub. (3) Confused residents must be watched while in tub or shower so they don't turn on hot water, resulting in burns. (4) A confused person must be supervised when he smokes. (5) Any equipment which produces heat must be carefully watched when in use. Elderly people sometimes have decreased sensation and may not feel that the skin is being burned.
Identify the basic safety steps the nursing assistant must take to prevent falls.	c. Prevent falls from bed, chairs, wheelchairs - (1) Restrain resident who is likely to fall from bed or chair (per physicians order or instruction from the charge nurse). (2) Keep bedrails up. (3) Lock wheels on bed or wheelchair. (4) When transporting resident in bed, geriatric chair or wheelchair "drive safely", slowly, approaching corners with caution, with resident facing front.

Unit III (contd.)

OBJECTIVE	CONTENT
	(5) Use transfer belt or hold resident securely when transferring between bed and chair.
Identify basic steps the nursing assistant must take to prevent choking.	d. Prevent choking - (1) Make sure that food is cut or chopped in small enough pieces for resident to swallow. (2) Monitor the portions of food put into the residents mouth at one time. e. Prevent ingestion of harmful substances - Do not leave potentially poisonous or harmful substances at the bedside or places accessible to the residents (liquid soaps, skin medications).
Identify basic safety precautions for oxygen use.	2.3 Safety precautions for oxygen use: a. Precautions for oxygen safety should be posted outside the room where it is being used. b. Limit any situations which might start a fire because oxygen supports combustion. c. No smoking or open flame. d. Electrical equipment should be grounded. e. If an oxygen tank is used, it should be stabilized so it does not fall over.
Name causes of airway obstruction.	3. Airway Obstruction 3.1 Most frequent causes of airway obstruction: a. Elevated blood alcohol level. b. Upper and lower denture slippage. c. Large, unchewed pieces of food. d. Decreased swallowing ability due to weakness

Unit III (contd.)

OBJECTIVE	CONTENT
	in throat muscles. e. Laughing and talking.
List symptoms of possible air way obstruction.	3.2 Partial obstruction: a. Resident is able to take in and exhale some air. b. Results in weak cough. c. Causes high pitched sound while inhaling. d. Increases respiratory difficulty and possible cyanosis. e. If the victim can speak, cough, or breathe, DO NOT INTERFERE.
List symptoms of complete obstruction.	3.3 Complete obstruction: a. Resident is suddenly unable to speak, cough, make any sounds. b. Action to aid choking resident (complete obstruction). Emergency care must be given quickly since brain damage may begin within four minutes. The emergency action described here is called the abdominal thrust
Demonstrate the Heimlich Maneuver.	(Red Cross) or Heimlich Maneuver - (refer to procedure #26 in the Appendix) (1) Victim standing or sitting: -If feasible, ask the resident if he/she is choking. -Be aware that the victim may walk or run away due to fear. -Remain calm, give continuous reassurance. Tell the resident you are there to help him. -Perform per procedure in Appendix. -When the resident is sitting, the rescuer stands behind the

OBJECTIVE	CONTENT
	resident's chair and performs the maneuver in the same manner. (2) Victim lying down: -Place resident flat on back. -Facing resident, kneel astride hips. -With one of your hands on top of the other, place the heal of your bottom hand on the abdomen slightly above the navel and below the rib cage. -Press into the resident's abdomen with a quick upward thrust. -Repeat several times if necessary.

Unit IV
Promoting Independence/Respecting Resident's Rights
(3 hours theory/classroom lab)

OBJECTIVE	CONTENT
	1. Promoting Independence 1.1 Introduction: a. Everyone needs to feel control over their lives and environment. As people age, many find that their roles as workers and contributing family members diminish as physical capabilities and income declines. b. The best policy is to keep the elderly as an integral part of the community and help them maintain as much independence as possible in the face of increasing difficulty in performing daily activities.
Identify services that promote residents' independence.	1.2 Resident services: a. The highest level of resident participation should be encouraged. b. Encourage the resident to make their own choice and do things for themselves. c. Share the resident's careplan with the resident and family. Involving the resident in their own care stimulates a sense of responsibility. d. Be open to residents' suggestions, complaints and grievances. Comments from residents and their families should never be ignored. e. Resident councils provide an effective way for residents to meet for discussions and make recommendations regarding facility policies, programs, services and other issues. f. It is important to encourage a resident to attend activities. Activities expand horizons, challenge the mind, body and intellect; provide a

OBJECTIVE | CONTENT

way to fight loneliness and depression; encourage independence and individuality.

g. Report personal dietary preferences of the resident to the charge nurse or dietary manager. With deteriorating sense of smell due to aging tastebuds or medication effects, presentation of food becomes especially important.

h. Promote the resident's level of independence in managing Activities of Daily Living -
   (1) Ability to move about the environment independently
   (2) Ability to eat independently.
   (3) Ability to maintain personal hygiene.
   (4) Ability to dress independently and appropriately.
   (5) Ability to care for toileting needs.

1.3 Fundamental philosophies of promoting independence:

a. Recognize and help the resident and family to accept the frail years as a natural and positive part of the lifecycle.

b. Within the facility encourage residents to continue with as familiar a lifestyle as possible.

c. Provide residents with opportunities for growth by encouraging and taking them to activities.

d. Emphasize the involvement of family members that there is still an important role and place for them in a resident's life. Encourage volunteerism.

e. Focus on the resident's physical and mental capabilities to maintain the optimum level

OBJECTIVE | **CONTENT**

of functioning.

2. Resident Rights
   2.1 Arkansas nursing facility residents have all the rights of U.S. citizens as guaranteed by the Constitution of the United States of America.
   - a. Every resident admitted to an Arkansas nursing facility is informed of specific RESIDENT'S RIGHTS. The staff of the nursing facility is to be informed and protect the rights of residents. This will contribute to more effective resident care by enumerating the responsibilities of physician, staff and facility.
   - b. Resident's Rights may vary from facility to facility but as a minimum the list of rights shall include the following:
     - (1) The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility must assert, protect, and facilitate the exercise of these rights.
     - (2) The resident has the right to be fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services. The facility makes available to residents, a list of the kinds of services and articles provided by the

OBJECTIVE	CONTENT
	facility. Charges for all services and supplies not included in the facility's basic per diem rate are identified. Residents are informed in writing in advance of any changes in the costs or availability of services. The resident has the right to be informed of the rules of the facility upon admission in the language that he/she understands.
	(3) The resident has the right to exercise rights as a resident, to exercise rights as a citizen or resident of the United States, including the right to file complaints. The resident has the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. The resident has the right to recommend changes in policies and services to facility staff and/or outside representatives of his/her choice, free from coercion, discrimination, or reprisal.
	(4) The resident has the right to information on Federal, state and local agencies concerned with enforcement of long term

OBJECTIVE

CONTENT

care facility rules and agencies acting as resident advocates and is afforded the opportunity to contact these agencies. The resident has the right to participate in a representative resident council in the facility. The resident has the right to make choices about significant aspects of his/her life in the facility.

(5) The resident has the right to be informed of his/her medical condition and an opportunity to participate in planning his/her medical treatment unless contradicted (as documented by a physician in the medical record). The resident has the right to choose a personal attending physician. The resident has the right to be informed in advance of any changes in care or treatment that may affect his/her well-being, unless medically contradicted. The resident has the right to refuse treatment and to refuse to participate in experimental research. The resident has the right to be advised of alternative courses of care and treatments and their consequences when such alternatives are available.

(6) The resident has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion,

OBJECTIVE | CONTENT

and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. The resident has the right to be free from unnecessary drugs and physical restraints and is provided treatment to reduce dependency on drugs and physical restraint. Restraints may only be imposed:

-To ensure the physical safety of the resident or other residents.

-Only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances until such an order could reasonably be obtained). The resident has the right to be free from physical, psychological or sexual abuse or punishment.

(7) The resident has the right to manage his or her financial affairs. If the facility manages the financial affairs of the resident, the facility must comply with federal and state rules and regulations.

(8) The resident has the right to confidentiality, of personal and clinical records. The resident has the right to approve or refuse the release of information of personal and

OBJECTIVE

CONTENT

clinical records to any individual or agency outside the facility, except, in case of his transfer to another health care institution or as required by law or third party payment contract. The resident has the right to approve or refuse to allow photographs to be taken or interviews to be conducted.

(9) The resident has the right to personal privacy. The resident has the right to privacy with regard to accommodations, medical treatment, written and telephone communications, visits, and meetings of friends, family and of resident groups, unless medically contradicted.

(10) The resident has the right to send and receive mail that is not opened.

(11) The resident has the right to receive visitors at any reasonable hour and by arrangements at other times.

(12) The resident has the right to have access to the private use of a telephone.

(13) The resident has the right to reside and receive services with reasonable accommodations of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered and to receive notice before the room

OBJECTIVE

CONTENT

or roommate of the resident in the facility is changed.

(14) The resident has the right to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(15) The resident has the right to participate and/or refuse to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(16) The resident has the right not to perform services for the facility and to be compensated for services voluntarily performed, unless informed prior to performing services that services are of a voluntary nature and will not be compensated (unless the services are for therapeutic purposes in the residents plan of care as ordered by the attending physician).

(17) The resident has the right to retain and use personal possessions and appropriate clothing, within space allocated by the facility, unless to do so would infringe upon the rights or security of other residents.

(18) The resident has the right to privacy of visits with spouse. If both are residents, they

OBJECTIVE

CONTENT

have the right to share a room unless medically contraindicated and documented by the physician in the medical record.

(19) The resident has the right to be provided a safe, clean, comfortable and homelike environment.

(20) The resident has the right to be provided food that is attractive, proper temperature, meets individual needs.

(21) The resident has the right to be provided an on going program of activities appropriate to residents needs and interests, designed to promote opportunities for engaging in normal pursuits, including religious activities of choice.

(22) The resident has the right to receive the necessary nursing, medical and psycosocial services to attain and maintain the highest possible mental and physical functional status as defined by a comprehensive assessment and plan of care.

(23) The resident has the right to remain in the facility and not to be transferred or discharged unless:

- the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility.
- the transfer or discharge is appropriate

OBJECTIVE CONTENT

because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

-the safety of individuals in the facility is endangered.

-the resident has failed, after reasonable and appropriate notice, to pay an allowable charge imposed by the facility for an item or service requested by the resident and for which a charge may be imposed consistent with Title XIX.

-the facility ceases to operate. In each case, the basis for the transfer or discharge must be documented in the resident's clinical record by the resident's physician. Appropriate notice must be made in advance of the resident's transfer or discharge except in urgent medical needs.

(24) The resident has the right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the governing agency (in Arkansas, the Office of Long Term Care) with respect to the facility and any plan of correction in effect with the facility.

(25) A resident's next of kin or legal guardian may exercise a resident's

OBJECTIVE	CONTENT
	rights when a resident has been ruled incompetent by a Judge in a a court of law. c. These rights are not all encompassing, but are specific to long term care facilities. Each facility is responsible for developing its own Resident's Rights policy and procedures for implementing these rights and may make additions to this list of Resident's Rights. 2.2 The nursing assistant is ethically responsible and legally accountable for upholding and protecting Resident's Rights in providing the resident's care:
Identify the treatment a nursing assistant shall have toward the resident.	a. Refer to Resident's Rights #1 - This is the responsibility of any staff member who has contact with the resident - (1) The nursing assistant shall treat the resident as a fellow human with consideration, respect, and full recognition of the resident's dignity and individuality. (2) The nursing assistant shall always treat the resident as she/he would want to be treated. b. Refer to Resident's Rights #2 - (1) This is the responsibility of administration.
Identify the nursing assistant's responsibilities concerning resident's grievances.	c. Refer to Resident's Rights #3 - (1) It is the role of administration to develop and follow a procedure for the registration and disposition of grievances by the resident/family/legal representative. (2) It is the responsibility

Unit IV (contd.)

OBJECTIVE	CONTENT
	of the nursing assistant to report grievances as told per a resident by facility policy and procedures to the appropriate authority. (3) The nursing assistant shall encourage the resident to exercise the Resident's Rights. (4) A nursing assistant is to NEVER coerce, discriminate or give reprisal to a resident who voices grievances. d. Refer to Resident's Rights #4 - (1) This is the responsibility of administration.
Identify the person responsible to keep the resident informed of medical condition.	e. Refer to Resident's Rights #5 - (1) It is the responsibility of the physician to inform and keep the resident updated to medical condition.
Identify the nursing assistant's responsibility if asked about a resident's medical condition.	(2) Any questions or opinions asked of the nursing assistant about the condition of the resident are to be politely but firmly referred to the charge nurse as upholding the Resident's Rights. (3) The nursing assistant shall refrain from giving or expressing opinions about the resident's condition or treatment. f. Refer to Resident's Rights #6 -
Identify where the nursing assistant receives instructions to restrain a resident.	(1) The nursing assistant receives instructions for restraining the resident from the charge nurse. (2) The nursing assistant shall be held responsible for knowing Office of Long Term Care rules and

Unit IV (contd.)

OBJECTIVE	CONTENT
	regulations and the facility's policy and procedures regarding restraints. (Refer to section on Restraints.
Identify result of not reporting knowledge of abuse, neglect, exploitation of a resident.	(3) Persons are required by law to report suspected adult abuse, neglect, or exploitation. Persons who have knowledge of suspected adult abuse, neglect, or exploitation and do not report it become an accomplice to the act. (See unit on "Ethics and Legal Aspects"). The nursing assistant is responsible for reporting incidents per facility policy and procedure.
	(4) Avoiding the need for restraints in accordance with current professional standards: -Staff education. -Structured activities. -Attention to individual needs. -Drug dose reductions. -Diversion.
	g. Refer to Resident's Rights #7 - (1) This is the responsibility of administration.
Identify areas of confidentiality.	h. Refer to Resident's Rights #8 - (1) Confidentiality extends beyond the medical records to include all aspects about the residents; personal information, behavior, mental condition, physical condition, etc.
Give appropriate response to questions regarding resident's condition.	(2) When questions are asked of the nursing assistant about the condition of the resident, refer them

OBJECTIVE	CONTENT
	to the charge nurse. Be polite, let it be known that interest is appreciated, but THAT ALL INFORMATION REGARDING THE RESIDENT IS CONFIDENTIAL AND CANNOT BE DISCUSSED.
Identify areas of breaking confidentiality.	(3) Examples of breaking confidentiality: -Discussing one resident with another resident. -Discussing a resident's condition with relatives or friends of the resident. -Discussing a resident's condition with the nursing assistant's own family or friends. -Discussing a resident's condition with another staff member in front of another resident, visitor, etc. -Discussing a resident's condition with the news media. -Discussing a resident's condition with fellow workers, except when in conference or in planning resident care. -Anyone requesting to review the medical records of a resident is to be referred to the charge nurse.
Identify ways the nursing assistant provides resident privacy.	i. Refer to Resident's Rights #9 - (1) The nursing assistant shall knock on a closed door and announce entry into the room before opening the door. (2) The nursing assistant shall provide for privacy of the resident during all aspects of care by

OBJECTIVE	CONTENT
	closing the window curtain to screen from public and by closing the door to the room where care is being given and by the use of privacy screens and curtains. (3) The nursing assistant shall request that persons not involved with the care of the resident are not present during care/examination/treatment without consent of the resident. j. Refer to Resident's Rights #10 - (1) This is the responsibility of the administration. k. Refer to Resident's Rights #11 - (1) This is the responsibility of the administration. l. Refer to Resident's Rights #12 - (1) This is the responsibility of the administration. m. Refer to Resident's Rights #13 - (1) This is the responsibility of the administration. n. Refer to Resident's Rights #14 - (1) This is the responsibility of the administration. o. Refer to Resident's Rights #15 - (1) This is the responsibility of the administration.
Identify the responsibility of the nursing assistant in encouraging self-care.	p. Refer to Resident's Rights #16 - (1) It is the responsibility of the nursing assistant

OBJECTIVE	CONTENT
	to attempt to get the resident to perform as many personal care tasks as possible, but NEVER to force a resident to care for self. (2) It is the responsibility of the nursing assistant to encourage the resident to attend activities provided by the facility and to attend meals in the dining room, but NEVER to force attendance. (3) It is the responsibility of the nursing assistant to inform the charge nurse of resident refusal to participate in self-care/activities. (4) The nursing assistant shall ask the charge nurse for the appropriate manner for handling a resident's refusal of self-care/activities.
Identify when a nursing assistant is to report concerning resident's personal possessions.	q. Refer to Resident's Rights #17 - (1) It is the responsibility to report to the charge nurse if it appears that a resident's personal possessions or clothing infringes upon the rights or security of others. (2) The nursing assistant shall report to the charge nurse if a resident does not appear to have appropriate clothing. r. Refer to Resident's Rights #18 - (1) This is the responsibility of the administration. s. Refer to Resident's Rights #19 - (1) Refer to sections on

Unit IV (contd.)

OBJECTIVE	CONTENT
	providing a resident a safe environment and care of the resident's unit. t. Refer to Resident's Rights #20 - (1) Refer to sections on nutrition.
Identify the nursing assistant's role in resident's participation in activities.	u. Refer to Resident's Rights #21 - (1) The nursing assistant shall not impose religious beliefs on the residents. (2) The nursing assistant shall encourage but not force the resident to be a participant at activities.
Identify the nursing assistant's role in nursing service.	v. Refer to Resident's Rights #22 - (1) The nursing assistant shall provide nursing care per the instructions of the charge nurse and per the resident's individualized plan of care. w. Refer to Resident's Rights #23 - (1) Transfer/discharge arrangements are made per physician and administration. (2) The nursing assistant shall make every effort to make this change easy and pleasant. (3) The nursing assistant shall be sure that all personal belongings are sent with the resident and inventory forms are completed and signed appropriately per facility policy. x. Refer to Resident's Rights #24 - (1) This is the responsibility of the administration.

Unit IV (contd.)

OBJECTIVE	CONTENT
	y. Refer to Resident's Rights #25 - (1) This is the responsibility of the administration. 2.3 Civil Rights of the resident: a. Facilities are to admit and treat all residents without regard to race, color, national origin, religious preference, or marital status. b. The same requirements for admission are applied to all and residents are assigned within the facility without regard to race, color, national origin, or religious preference. c. There is no distinction in eligibility for, or in the manner of providing, any resident service provided by or through the nursing home. d. All facilities of the nursing home are available without distinction to all residents and visitors regardless of race, color, national origin, religious preference or marital status. e. All persons and organizations having occasion either to refer residents for admission or to recommend the facility are advised to do so without regard to the resident's race, color, national origin, religious preference, or marital status.
Identify areas the nursing assistant is held responsible for by law.	2.4 In Arkansas, adults are subject to the protection of the Department of Human Services, if endangered, abused, maltreated, exploited, or neglected: a. Endangered Adult - an adult eighteen years or older who is found to be in a situation or condition which poses an

OBJECTIVE	CONTENT
	imminent risk of death or serious harm to such person who demonstrates the lack of capacity to comprehend the nature and consequence of remaining in that situation or condition. b. Abuse/Maltreatment - any willful or negligent act which results in negligence, malnutrition, physical assault or battery, physical or psychological injury inflicted by other than accidential means, and failure to provide necessary treatment, rehabilitation, care, sustenance, clothing, shelter, supervision, or medical services. c. Exploitation - any unjust or improper use of another person for one's own profit or advantage. d. Whoever, willfully or by culpable negligence, deprives an adult of, or allows an adult to be deprived of necessary food, clothing, shelter, or medical treatment, or who knowingly or by culpable negligence permits the physical or mental health of the adult to materially endangered, and in so doing causes great bodily harm, permanent disability, or permanent disfigurement to the adult, shall be guilty of a Class D felony and shall be punished by law.
	3. Ethics and Legal Aspects
Identify ethical responsibilities of the nursing assistant.	3.1 Ethical responsibilities - A set of standards and moral principles governing the conduct of a nursing assistant. It deals with the relationship of a nursing assistant; to a resident, to

OBJECTIVE	CONTENT
	families, to the teammates and associates, to the community:
List ethical responsibilities of the nursing assistant.	a. Integrity - (1) Honesty. (2) Sincerity. (3) Reliability. (4) Carrying out responsibilities of assignments.
Recognize factors which identify the nursing assistant's loyalty to the resident and to the employer.	b. Loyalty - (1) to resident. (2) to employer. c. Performs only those duties which he/she is prepared and which are authorized. d. Respect religious rights and preferences - (1) of residents. (2) of teammates.
Identify ethical responsibilities of the nursing assistant in caring for the resident.	e. Nursing assistant ethical responsibility in caring for the resident - (1) Expected to know content of job description. (2) Expected to know and anticipate the various types of behavior which residents may develop. (3) Expected to be responsible for own acts in providing competent basic care to residents. (4) Expected to perform only those activities for which prepared and which are authorized. (5) Expected to be responsible for helping maintain a safe environment. (6) Expected to be responsible for safeguarding the resident's possessions. f. The nursing assistant does not talk about the resident's behavior in a negative and/or condescending manner. g. The nursing assistant is expected to use a positive approach to meet the resi-

OBJECTIVE	CONTENT
	dent's needs. h. The nursing assistant is expected to listen to the resident with a non-judgmental attitude and reflects the resident's feelings rather than his words. i. The nursing assistant is expected to meet the residents on their own level, is truthful, always keep promises, and is consistent in activities and attitudes. j. The nursing assistant acts to meet the resident's needs rather than own needs. k. The nursing assistant is expected to respect the resident's feelings and protects the resident's right to privacy. l. The nursing assistants assigned residents are the nursing assistant's kingdom. The nursing assistant must always be on guard against becoming authoritative as the residents may interpret the nursing assistants commands as law. m. The nursing assistant must probe and focus on fact rather than feelings. The question "Why?" puts the resident on the defense. It may cause confusion and disorientation as to time, place, person.
Identify examples of confidentiality.	3.2 Confidentiality: a. Confidentiality means keeping resident's personal information private. b. Examples of confidentiality - Do not discuss personal resident information with - (1) One resident about another resident. (2) Relatives or friends of

Unit IV (contd.)

OBJECTIVE	CONTENT
	the resident. (3) Representatives of the news media. (4) Fellow workers, except when in conference or in planning resident care. (5) One's own family and friends. 3.3 Respect and uphold the residents' rights: These rights are of such vital importance that "Rights" are addressed in a separate unit. 3.4 Respect and dignity are integral aspects of all care and relationships with residents, families, teammates, and community.
Identify the nursing assistants' legal responsibilities in caring for resident.	3.5 Legal Aspects: a. Nursing assistant's legal responsibility in caring for residents - (1) Is to know the content of the job description. (2) Is to know and anticipate the various types of hazards which may develop for residents.
Identify what conditions the nursing assistant may be held liable for negligence.	b. The nursing assistant may be held liable, if in the opinion of the court, the nursing assistant was negligent in providing protection and care constituting PREVENTION against the development of any situation INJURIOUS to the resident. c. The nursing assistant is legally responsible for carrying out procedures and carrying them out correctly.
Define battery.	d. Battery - physical abuse to resident - (1) Pushing. (2) Shoving. (3) Pinching. (4) Holding the resident too tight. (5) Tripping.

Unit IV (contd.)

OBJECTIVE	CONTENT
	(6) Pulling. (7) Hitting.
Define harassment.	e. Harassment - mental and emotional abuse. It can be verbal and/or non-verbal - (1) Argumental with the resident. (2) Making fun of resident behavior. (3) Harsh and/or derogatory (cursing) words. (4) Condescending tone of voice; hateful, derogatory. (5) Laughing at resident. (6) Making fun of resident. (7) Being judgmental. (8) Shaming residents for the way they eat, talk, walk, etc.
	f. The nursing assistant is responsible for own acts in providing competent basic care to residents. g. The nursing assistant performs only those activities or duties for which prepared and which are authorized. h. The nursing assistant is responsible for helping to maintain a safe environment for the resident. i. The nursing assistant is responsible for helping safeguard the resident's possessions. (Don't steal from the resident or from the facility). j. All staff have a legal responsibility to respect and uphold the rights of the residents.
Define each area of legal concern.	k. Areas of legal concern - (1) Libel. (2) Negligence. (3) Abuse. (4) Battery. (5) Assault. (6) Invasion of resident

OBJECTIVE	CONTENT
	privacy. (7) Defamation: -slander. -libel. (8) Exploitation. (9) Self abuse.
State Arkansas law as it relates to reporting of abuse, neglect or exploitation of a resident.	3.6 Reporting and Investigation: a. Persons are required by law to report suspected adult abuse, neglect, or exploitation. Persons, who are acting in good faith, have immunity from civil or criminal liability that might result from this action.
Identify nursing assistant's responsibility in reporting suspect abuse or neglect of the resident.	b. Persons failing to report suspected abuse, neglect, or exploitation if they know about it become accomplices to the act.
	c. Truthful statements and facts (not your feelings or interpretations of events) are to be given during an investigation.
Identify the agencies responsible to investigate suspected abuse, neglect or exploitation of residents.	d. Violations of all reported incidents of failure to maintain legal aspects will be investigated by the Office of Long Term Care and/or the Attorney Generals Office and/or the state or local police.

Unit V
Introduction to Resident Care
(5 hours theory/classroom lab)

OBJECTIVE

Identify measures which make the bed safe and comfortable.

CONTENT

1. Bedmaking - 2 hours
   - 1.1 Making a comfortable bed:
     - a. Older people have less tissue padding over their bones and wrinkles can actually cause them pain.
     - b. The resident's skin is very easily damaged. Wrinkles can restrict circulation resulting in pressure areas (bedsores/ decubiti).
     - c. If a resident is unable to get out of bed, all activities of daily living will be carried out in bed.
     - d. Residents who remain in bed all of the time need their linens straightened and checked frequently throughout the day and night.
     - e. Many times residents are incontinent of urine and/or feces. Check these residents frequently. Change linens when soiled.
   - 1.2 Types of bedmaking:
     - a. Unoccupied - The resident is able to leave the bed while it is made.

       Closed bed -
       - (1) Is made with the top sheets and spread pulled all the way up.
       - (2) Is usually used if the resident is to remain up for most of the day.
       - (3) The pillow can be enclosed or left out depending upon the facility.

       Open bed -
       - (1) Has the top sheet and spread fan-folded to the bottom of the bed.
       - (2) Allows easy access by the resident and when

OBJECTIVE	CONTENT
	in, bed sheets and spread can be pulled up easily by the resident. b. Occupied bed (see Unit VI).
Identify and demonstrate measures of bedmaking (unoccupied - open and closed).	1.3 Measures of bedmaking: (refer to procedure #27 in the Appendix) a. Measures for resident comfort - (1) Preventing wrinkles. (2) Allowing toe room. b. Measures for resident safety - (1) Using bedrails. (2) Having bed in lowest position to floor. c. Measures for infection control - (1) Don't shake linens. (2) Linens are not to be on floor. (3) Carry clean and dirty linens away from uniform. (4) Place linens in dirty linen hamper, not in with resident's dirty clothes. (5) Wash your hands. d. Use good body mechanics.
	2. Meal Service - 2 hours
List steps to promote a positive environment at mealtime.	2.1 Assisting the resident at mealtime: a. Promoting a positive atmosphere for mealtime - (1) The resident should be physically comfortable. (2) The surrounding should be pleasant and comfortable. (3) The social aspect of mealtime should be considered. (4) Residents who are physically able should eat in the dining room rather than in the

Unit V (contd.)

OBJECTIVE	CONTENT
	isolation of their rooms.
Identify steps to help residents remain independent while eating.	(5) The resident should be encouraged to remain independent; food is provided in a manageable form (e.g. bread is buttered, meat cut). Assist visually impaired persons in locating food and utensils.
Demonstrate assisting devices.	(6) Use special eating devices such as a plate guard or adapted spoon to aid handicapped residents in self-feeding. b. A resident may require a therapeutic diet, which is prescribed by the doctor, and planned by the dietitian. Therefore, do not interchange food from one resident's tray to another. Never eat food served to a resident, even if the resident does not want it.
Identify and demonstrate measures of serving a tray correctly.	c. Serving a tray correctly - (refer to procedure #8 in the Appendix) (1) Wash your hands. (2) Diet card must accompany tray to resident's room (OLTC Regulation). (3) Check diet card for: -Name of resident. -Special instructions. -Diet order. -Allergies. (4) Observe the food content of tray, if there is a question about content versus diet card, return the tray to the kitchen/serving personnel. (5) Check tray for necessary items:

OBJECTIVE | CONTENT

-Self-help devices.
-Napkin on tray or table.
-Condiments.
(6) Prepare tray and food.
(7) Place tray according to need such as visual impairment, weakness, paralysis, etc.
(8) Serve tray immediately.
d. Encourage and assist the resident as needed -
(1) Open pre-packaged food and condiments.
(2) Cut up food.
(3) Place butter and jelly on bread
e. For vision impaired -
(1) Place silverware, cup, etc. in same place each time.
(2) Ask resident if assistance is needed:
-If no, respect resident's wishes.
-If rendering assistance, tell what foods are on tray in clockface order.
f. Feeding a resident - Refer to Unit VI, #5.

Describe how to report changes in eating habits of residents and other pertinent information.

2.2 Reporting/recording:
a. Amounts consumed of food and fluids.
b. Difficulty of resident -
(1) Drinking.
(2) Chewing.
(3) Swallowing.
c. If resident is refusing to eat.
d. If resident is eating less than usual.
e. The need for special eating utensils -
(1) Spoons, forks.
(2) Cup and/or plate.
f. Report complaints/recommendations for seating changes at dining table to charge nurse.

OBJECTIVE	CONTENT
	3. Caring for the Resident's Environment - 1 hour 3.1 The Resident's Unit - Proper furniture and equipment
Identify ways of keeping the resident's environment comfortable.	3.2 Ways of providing environmental comfort in the resident's unit: a. Provide ventilation according to the resident's preference and condition. b. Adjust temperature for personal differences, keeping in mind that the elderly cannot adjust as well to extremes of temperatures. c. Provide extra humidity for residents with respiratory disorders, as directed by the nurse in charge. d. Adjust lighting for day and night safety. Place lights to avoid glaring.
Identify steps to be taken to assure the resident's unit is safe and completely furnished.	3.3 Daily maintenance of the resident's unit: a. Be sure call bell is within reach (OLTC Regulation). Do this EACH TIME YOU LEAVE THE RESIDENT'S UNIT. This is VERY IMPORTANT to remember. Accidents happen when residents try to help themselves. b. Chairs should be placed out of the mainstream of traffic areas, when not in use by the residents. c. Urinal should be within easy reach of male residents. Urinal needs to be emptied to prevent spilling (OLTC Regulation). d. The bedside stand should be within easy reach and contain items used frequently by the resident. Discourage hoarding while being sensitive to resi-

OBJECTIVE CONTENT

dent's desires.

e. Fluids should be offered at frequent intervals. Water pitchers shall be refilled at least once each shift and should be kept in reach of patients. Clean drinking glasses shall be kept with each water pitcher (OLTC Regulation).

f. The bed should always be in the lowest position. In case of falls, the resident is closer to the floor which might prevent serious injuries.

g. Bed rails should be used consistently as the patient's condition requires.

h. Each time you enter a resident's unit, look around for possible dangers such as spills on the floor, items that could trip someone, frayed electrical cords.

i. The unit should be cleaned daily. The nursing assistant or resident should straighten the resident's personal belongings. Housekeeping personnel will clean the remainder of the room.

PART II

CLASSROOM & CLINICAL TRAINING - 59 HOURS

(Theory, Classroom Lab, and Clinical)

NOTE: Each Unit in Part II has the required number of hours specified, accounting for classroom activity (theory and lab) and clinical on the floor. Each sub-unit has the number of hours specified for the classroom activity (theory/lab) but not clinical. Clinical training shall take place at the end of each Unit, with the students performing tasks/skills under the supervision of the instructor.

NOTE: The trainee may work in the staffing of a facility while completing Part II of the training course. However, the trainee can only perform the task/skills they have been trained and determined as competent to perform.

Unit VI
Personal Care Skills
(23 hours theory/lab and 7 hours clinical)

OBJECTIVE	CONTENT
	1. Bathing - 4 hours
List factors which affect a resident's hygiene needs and practices.	1.1 Factors affecting hygiene needs and practices: a. Proper hygiene promotes health and helps to prevent infection. b. The condition of the resident may change frequency of care. c. Individuals have preferences based on past habits. Allow flexibility in hygiene routines while maintaining standards of cleanliness.
Identify purposes for bathing.	1.2 Reasons for bathing: a. Clean the skin. b. Eliminate odors. c. Cool and refresh. d. Stimulate circulation.
Identify types of baths.	1.3 Types of baths: a. Complete bed bath - For the resident who too weak or sick to assist with their bathing. b. Partial bed bath - For the resident who is able to take care of most of their own bathing needs. The nursing assistant will bathe only the areas that are hard to reach. c. Whirlpool bath - For the resident whose doctor may order for therapeutic reasons. d. Tub/shower bath - For residents who are strong enough to get out of bed and walk around.
Identify guidelines to follow when bathing the resident.	1.4 Guidelines for bathing: a. Protect the resident's modesty and prevent chilling by closing the door, drawing the curtains and exposing the resident as little as possible. b. Soap can dry out the skin, especially on the elderly. Be sure to rinse the soap off well. Special cleaning and/or

OBJECTIVE	CONTENT
	moisturizing liquids may be used.
Demonstrate bathing techniques: (1) Bed bath. (2) Tub bath. (3) Shower. (4) Whirlpool.	c. Bathe per accepted procedure-(refer to procedures #40, 42, & 43 in the Appendix) (1) Keeping water temperature comfortably warm and clean. Water should be aproximately 100 degrees or comfortable when felt on back of hand or elbow. (2) Making a mitt from the washcloth or showing other methods of keeping tails of washcloth under control. (3) Washing and drying one part of the body at a time. (4) Giving a backrub and massaging other bony prominences with warmed lotion. d. Never leave the resident unattended. e. Examine the resident's skin during bath. Carefully clean under all skin folds and in contracted areas. Report any changes in skin; redness, rashes, broken skin or tender places. f. Give range of motion exercises (ROM) during bath time (see Unit IX). g. Follow procedures for cleaning bathing area.
	1.5 Backrub:
List purposes for a backrub.	a. Purpose - (1) Refresh and relax resident. (2) Stimulate circulation.
Demonstrate backrub.	b. Backrub per accepted procedure (refer to procedure #24 in the Appendix).
	2. Grooming - 4 hours 2.1 Oral hygiene - cleaning the

Unit VI (contd.)

OBJECTIVE	CONTENT
	resident's mouth, lips, and teeth:
List purposes for oral hygiene.	a. Purpose - (1) Helps prevent inflamation to mouth and gums and damage to the teeth by removing food particles which promote bacterial growth. (2) Refreshes the resident's mouth.
Identify and demonstrate measures of oral hygiene.	b. General practices/measures - (refer to procedure #15 in the Appendix) (1) Brush teeth or dentures at a minimum in the morning and at bedtime. (OLTC Regulation) (2) Use soft, moist brush. (3) Encourage the resident to help as much as possible. (4) Gently cleanse tongue, teeth and gums. (5) Take special care to rinse out resident's mouth. (6) Check teeth, gums, tongue for changes in color, shape, loose teeth, ulcers, odor, etc.
Identify and demonstrate measures of denture care.	c. Denture care (partial or full) - (refer to procedure #16 in the Appendix) (1) Dentures are slippery, handle with care. (2) Cleanse denture per accepted procedure. (3) Resident is to rinse out mouth, using water or mouthwash and brush gums and tongue with soft, moist toothbrush. (4) Return dentures to resident, replacing in mouth while moist. (5) Store dentures in fresh water or prepared solution when not in use.

OBJECTIVE	CONTENT
Identify and demonstrate measures of oral hygiene for the unconscious resident.	d. Mouth care for the unconscious resident - (refer to procedure #47 in the Appendix) (1) Mouth care for the unconscious resident must be done more frequently than regular mouth care, since the resident may not have enough saliva secretion to keep mouth moist. Lips and gums may become cracked and sore. (2) Position on side or have head turned to side to keep liquids from running down throat. (3) Use packaged mouth care swab or gauze wrapped tongue blades moistened in mouthwash. (4) Wipe all mouth surfaces. (5) Explain each step of the procedure to the unconscious resident. Even though a resident seems to be unconscious, they still may be able to hear you. (6) Keep mouth and lips moistened continuously.
Identify and demonstrate measures of hair care.	2.2 Hair Care: a. Shampooing a resident's hair- (refer to procedure #21 in the Appendix) (1) The cleanliness and grooming of both men's and women's hair is frequently associated with a resident's sense of well-being. (2) The frequency with which a resident needs to have hair shampooed is highly individualized. Hair is to be shampooed at least weekly (OLTC Regulation). (3) If a resident's hair tends to tangle after it

OBJECTIVE	CONTENT
	has been washed, a conditioning rinse is to be used. (4) All of the shampoo is to be rinsed out of the hair to prevent drying and itching of the scalp.
Identify and demonstrate measures of combing the resident's hair.	b. Combing a resident's hair - (refer to procedure #22 in the Appendix) (1) Hair is to be combed at least daily and kept neat at all times. (2) Residents feel better about self if hair is combed and styled attractively. (3) Brushing and combing the hair stimulates the blood circulation in the scalp. It brings oils to the surface and spreads them evenly over the hair. (4) Brush up from the neck toward the top of the head. This stimulates the scalp and assists the hair to fall in place naturally. (5) While combing, hold a small section of hair between the scalp and comb to prevent pulling. If the hair is long, start at the ends and work towards the scalp. (6) Try to style hair the way the resident likes it. (7) Residents are to always be encouraged to comb their own hair. c. Beard care - (1) Wash beard either when hair is shampooed or with bath. (2) Wash beard more often if food or liquid is frequently spilled in beard. (3) Comb or brush beard when

OBJECTIVE	CONTENT
	hair is groomed. (4) Trim as needed.
	2.3 Nail Care: (refer to procedure #19 in the Appendix)
Identify and demonstrate measures of proper nail care.	a. Nails are to be cleaned at bathtime. b. Soaking the nails in warm, soapy water helps to loosen any material that might have collected. c. Be careful when cleaning the nails not to injure the skin surrounding the nail itself. d. Fingernails are to be trimmed to an oval shape. Toenails are to be cut straight across with a blunt-tipped scissors or heavy nail clippers. e. Nails of a diabetic resident or a resident with poor circulation are to be cut with extreme care. Check with charge nurse. f. Nails are to be given care every two weeks or more frequently as needed. (OLTC Regulation)
	2.4 Shaving: (refer to procedure #18 in the Appendix) a. All male residents shall be shaved every other day or as needed, unless they have a beard (OLTC Regulation).
Demonstrate shaving of a male resident.	b. Encourage male residents to shave themselves and assist as needed. c. Shave and care for equipment per accepted procedure.
	2.5 Foot Care: a. Feet need special care. b. Apply lotion to feet and toenails daily. c. Observe for changes in feet and report changes to charge nurse -
Identify changes in feet to report to charge nurse.	(1) red spots. (2) corns or callouses.

OBJECTIVE	CONTENT
Identify and demonstrate measures of foot care.	(3) cracks in feet or toenails. (4) loose toenails. (5) swelling/edema. (6) pain. d. Observe and report too tight socks, shoes, stockings, etc. e. Use footboards to prevent - (1) footdrop. (2) pressure from linens. f. Follow accepted procedure (refer to procedure #20 in the Appendix).
Identify and demonstrate measures of dressing and undressing a resident.	3. Dressing - 1.5 hours 3.1 Dressing and undressing a resident: (refer to procedure #25 in the Appendix) a. Residents in a long term care facility should be dressed in their own "street" clothes whenever possible and their choice when feasible. b. Residents should dress themselves whenever possible. c. If they need assistance - (1) Remove one arm of a shirt or blouse at a time. Older people do not bend as easily as a younger person. (2) Sometimes raising both arms over the head and putting on or removing the sleeves on both arms at once prevents stretching of the shoulder muscles and pain, especially with people that have arthritis. (3) If the resident is paralyzed on one side, dress that arm or leg first and remove that arm or leg last from the clothing. (4) NEVER jerk or pull clothing off. Be gentle and

OBJECTIVE	CONTENT
	remove clothing slowly.
	4. Toileting/Elimination - 3.5 hours 4.1 Urinary Elimination: a. Urine -
Describe normal and abnormal appearance of urine and abnormal sensation while urinating.	(1) Normal appearance: -Straw colored. -Clear. (2) Abnormal appearance: -Cloudy - sedimentation in urine. -Dark - concentrated from medication and/or dehydration. -Red - blood in urine or medication. (3) Abnormal sensation: -Burning. -Painful urination. -Small amount. -Frequent voiding.
Identify and demonstrate measures of assisting a resident with bedpan, urinal or bedside commode.	b. Assisting the resident with urination (bedpan) - (refer to procedure #23 in the Appendix) (1) WASH YOUR HANDS. (2) Close door and curtain to provide for privacy. (3) Position resident comfortably: -Pillow behind back. -Elevate head of bed. -Warm bed pan before placing under resident. -Check frequently. (4) Use warm running water on hands, over perineum or other techniques to promote urination, if necessary. (5) Infection control: cleanse resident's perineum, hands and WASH HANDS of resident and self. c. Assisting a resident with urinal - (refer to procedure #1 in the Appendix)

OBJECTIVE	CONTENT
	(1) WASH HANDS. (2) Provide privacy. (3) Place urinal if resident is unable to do so. (4) Urination for the male may be easier if he can stand up to use the urinal or sit on side of bed. (5) WASH HANDS of resident and self.
	d. Assisting resident to use bedside commode or toilet - (1) WASH HANDS. (2) Provide privacy. (3) Stay with resident if necessary for safety. (4) Restrain per accepted facility procedure/physician order.
Identify and demonstrate steps in measuring and recording urinary output.	e. Measuring and recording of urinary output - (refer to procedure #3 in the Appendix) (1) Amount of urine. (2) Characteristics of urine; color, odor, appearance.
Identify and demonstrate measures for collecting urine specimens.	f. Collecting urine specimen - (refer to procedure #12 in the Appendix) (1) General guidelines: -WASH YOUR HANDS before and after obtaining specimen. -Right resident - right time-right method. -Cleanse perineum/penis before collecting specimen. -Label specimen correctly. -Store specimen correctly. -Report anything abnormal to charge nurse. (2) Reason for urinalysis: it tells the physician if any abnormalities or infections are present.

OBJECTIVE	CONTENT
	(3) Collecting a mid-stream urine specimen: -Used to determine if bacteria is present in the urine. -Strict asepsis must be obtained if urine is to be free of contamination.
Recognize how a urinary catheter works.	g. Urinary catheter care - (1) The urinary system is sterile, thus a nursing goal when a catheter is in place in the bladder is to avoid introducing microorganisims via the catheter drainage system. (2) A common reason for elderly residents to have a urinary catheter is to control incontinence, frequent UTI and poor skin condition. h. The closed drainage system consists of - (1) Catheter - a hollow tube having a small balloon at the end. The balloon is inflated after the catheter is inserted into the bladder to keep it from falling out. (2) Tubing - connects catheter to drainage bag. (3) Drainage bag - catches and stores the urine. Is to be emptied at the end of each shift. (4) The drainage bag may be a leg bag which straps to leg and allows more mobility. A leg bag should not be used by a resident when in bed. (5) Drainage bags or leg bags are to be changed only by a licenced nurse. i. Maintaining a closed system and prevention of urinary

OBJECTIVE	CONTENT
Identify and demonstrate measures of catheter and tubing care.	tract infection - (refer to procedure #36 in the Appendix) (1) To prevent microorganism from entering the body at any point along the drainage system. (2) Do not disconnect tubing at any point. (3) Do not allow tubing or bag to drag on the floor. (4) Never position catheter drainage bag above bladder. (5) Catheter shall be cleaned at point it enters the body (meatus) according to procedure. (6) Urine is emptied from clamp at the bottom of the bag. DON'T ALLOW TUBING END TO TOUCH CONTAINER into which urine is emptied.
Identify measures which help keep a urinary catheter draining correctly.	j. Maintaining continuous drainage of urinary catheter - (1) If the catheter does not drain, the bladder becomes distended. This can be harmful. (2) Observe to see that urine is flowing into catheter bag. DO THIS FREQUENTLY. If urine is not flowing, report this to the charge nurse. (3) Keep catheter and tubing free of kinks. (4) Keep resident from closing off tubing by keeping the resident from lying on tubing.
Identify measures to avoid injury to the bladder opening from pressure on the catheter.	k. Measures to avoid injury from pulling on the catheter - (1) Tape catheter to leg for females. (2) Tape catheter onto abdomen for males. (3) Fasten drainage bag to

Unit VI (contd.)

OBJECTIVE	CONTENT
	part of bed which moves with the resident. (DO NOT FASTEN BAG TO BED RAIL.) (4) Take catheter, tubing and bag everywhere with the resident. (5) If confused resident is pulling on catheter, sometimes trousers over catheter can prevent this.
Identify observations made about the catherized resident.	1. Observations/reporting/recording - (1) Amount of urine. (2) That urine is continually draining. (3) Characteristics of urine; color, odor, appearance. (4) Exudate at urinary opening. (5) Leaking anywhere in drainage system.
	4.2 Colon Elimination:
Describe normal and abnormal appearance of feces.	a. Appearance of feces (stool) - (1) Normal - bile-colored, formed, not necessarily one each day. (2) Abnormal - containing blood or mucous or undigested food: -Tarry. -Liquid. -Very dry and hard. -Clay colored.
	b. Constipation - (1) Symptoms: -Hard stool. -No stool. -Liquid seepage from anus. -Distention. -Flatus. -Discomfort (restlessness, irritability).
List measures to relieve constipation.	(2) Measures to relieve constipation: -Encourage the resident to take fluids.

Unit VI (contd.)

OBJECTIVE	CONTENT
	-Prompt response to the natural urge (usually after meals, especially after breakfast). -A diet which includes fruit, fiber, vegatables (allow enough time for meals to be eaten). -Exercise. -Proper positioning. -Provide privacy.
	c. Assisting the resident with elimination -
Demonstrate assisting the resident with a bedpan.	(1) Bedpan (refer to procedure #23 in the Appendix) (2) Bedside commode/toilet - (refer to 4.1,d. in this section).
Identify and demonstrate measures of a collecting fecal (stool) specimen.	d. Collecting a fecal (stool) specimen - (refer to procedure #11 in the Appendix) (1) Usually performed when infection or bleeding in the colon are suspected. (2) Make sure to collect the specimen in a bedpan or commode. (3) Do not allow the specimen to touch the outside of the collection container. (4) Use throatsticks to handle the specimen. (5) Make sure that the specimen is properly labeled and promptly transported.
Identify observations made about elimination.	e. Observation/reporting/recording - (1) Time. (2) Description: -Color. -Consistency (hard, soft, formed,liquid or loose) (3) Amount (smear, small, medium, large)
Define colostomy.	f. Colostomy - A surgical procedure which creates a new opening on the abdomen for release of solid waste

OBJECTIVE	CONTENT
	(feces) from the body.
Define ileostomy.	g. Ileostomy - A surgical procedure which creates a stoma on the abdomen for release of feces. The ileum (part of the small intestine) is brought to the abdomen.
	4.3 Fecal impaction:
Define fecal impaction.	a. Definition - hard stool caught in the lower bowel which prevents normal passage of feces.
List symptoms of fecal impaction.	b. Symptoms - (1) No normal stool. (2) Liquid fecal seepage from anus as small amount of fluid present in the colon is able to pass around the impacted mass. (3) Constant feeling of needing to have a bowel movement. (4) Rectal pain.
Identify causes of fecal impaction.	c. Causes of fecal impactions - (1) Decreased muscle tone or stimulation in the lower bowel. (2) Inactivity. (3) Inadequate fluid intake. (4) Insufficient bulk in diet. (5) Uncorrected constipation, which may be caused by any of the above.
Identify role of the nursing assistant in prevention of fecal impaction.	d. Role of the nursing assistant in prevention of fecal impactions - (1) Observe resident's bowel movements: -Amount. -Consistency (firm, formed, liquid, hard). -Frequency.
Identify and demonstrate measures of checking for a fecal impaction.	e. Checking for fecal impaction- (refer to procedure #31 in the Appendix) (1) This procedure is done by the nursing assistant

OBJECTIVE	CONTENT
	when directed to do so by the charge nurse. Some facilities do not allow nursing assistants to do this procedure. (2) The removal of fecal impactions are to be done by a licenced nurse only.
Identify the purpose of an enema.	4.4 Enema: a. Purpose - to cause the emptying of the lower bowel.
Identify and demonstrate measures of administering a prepackaged enema.	b. Prepackaged ready to use saline solution enema - (refer to procedure #32 in the Appendix) (1) To be administered upon instruction of the charge nurse. This is the only type of enema a nursing assistant may administer. (2) A small amount of saline solution pre-packaged in a squeezable plastic container with pre-lubricated tip is instilled into the rectum. If resident can hold this solution about 20 minutes, it pulls body fluid into the bowel, stretching it and thus causing evacuation. (3) Observe, report, and record according to procedure. c. All other types of enemas are to be administered by a licenced nurse.
	4.5 Incontinence: a. Incontinence is the loss of control of the bladder or bowel or both.
List physical causes of incontinence.	b. Physical causes - (1) Injuries. (2) Spasms. (3) Disease. (4) Loss of sphincter control
List psychological causes of incontinence.	c. Psychological causes - (1) Environment. (2) Lack of effort on part

OBJECTIVE	CONTENT
	of resident and nursing staff. (3) Poor motivation. (4) Stress. (5) Fear. (6) Anxiety. (7) Anger. (8) Frustration.
List signs/symptoms of a distented bladder to be reported to charge nurse.	d. Report any signs and/or symptoms of a distended bladder - (1) Dribbling. (2) Frequent small voidings. (3) Distention over pubic area.
Identify and demonstrate measures for incontinent care.	e. Measures for incontinent care - (refer to procedure #35 in the Appendix) (1) Maintain good skin condition. (2) Keep resident comfortable. (3) Check resident at least every two hours. (4) When resident is incontinent: -Wash and dry all affected skin. -Put on dry clean clothes -Change bed linens as necessary. (5) Use protective pads on bed. (6) May use an adult undergarment. (7) DO NOT scold or treat resident like a child.
Describe feelings/behavior of incontinent resident.	f. Feelings/behavior of the incontinent resident - (1) Embarrassment. (2) Frustration. (3) Anger. (4) Depression. (5) Withdrawal. (6) "Giving Up". (7) Shame. (8) Loss of self esteem. (9) Social rejection

Unit VI (contd.)

OBJECTIVE	CONTENT
Describe feelings of family of the incontinent resident.	g. Feelings of family of the incontinent resident - (1) Impatience. (2) Criticism (scolding). (3) Fear. (4) Denial. (5) Overly sympathetic.
Describe the proper attitudes/actions of the nursing assistant toward the incontinent resident.	h. Attitude/actions of the nursing assistant toward the incontinent resident - (1) The nursing assistant needs to explore feelings and attitudes about incontinence. (2) The nursing assistant must deal with self negative feelings/attitudes about incontinence. (3) The nursing assistant shall adopt a positive approach toward the incontinent resident: -Calm. -Matter of fact. -Pleasant.
	5. Feeding - 1.5 hours 5.1 Role of the nursing assistant in promoting good nutrition: a. The nursing assistant shall encourage the resident to eat a variety of foods presented at mealtime. The resident's food is prepared under the guidance of the food service supervisor and is planned as a balanced diet. b. A resident who is consistently unable to eat the prepared diet shall be identified to the charge nurse so that the diet can be modified to meet the resident's needs. 5.2 Feeding a resident: (refer to procedures #34 & 44 in the Appendix) a. To help prevent choking, assist the resident to a sitting position if possible.

OBJECTIVE | **CONTENT**

Identify and demonstrate measures of proper feeding techniques;
(1) for total feeding
(2) for syringe feeding
(3) for the vision impaired.

Raise the head of the bed if the resident is unable to get into a chair.

b. Protect the resident's clothing by using a bib or napkin. Encourage the resident to help by holding finger foods.
c. Feed hot foods and liquids cautiously to prevent injuring the resident.
d. Allow adequate time for the resident to chew thoroughly.
e. Offer only small amounts of food at a time and make sure the resident has swallowed all food before offering more.
f. Alternate liquids and solids as the resident prefers.
g. A feeding cup or feeding syringe should be used with care to prevent aspiration of liquid. The tip should be placed inside the resident's cheek instead of the top of the tongue providing opportunity to control the liquid and swallow it.
h. Vision impaired resident -
   (1) Describe food on the plate, as well as content of each bite.
   (2) Determine if the resident prefers one food at a time or a variety.
   (3) Allow resident to make as many choices as possible to help him/her feel less dependent.

Identify alternate methods of feeding.

5.3 Alternate methods of feeding:
a. Sometimes residents are too ill or weak to consume even a liquid diet.
b. Alternate methods of providing nutrition -
   (1) Nasogastric tube - introduced through the nose and into the stomach so that liquid or pureed

OBJECTIVE	CONTENT
	food may be directly feed (2) Gastrostomy (an opening into the stomach through the abdominal wall) may be made and feedings are given through a gastrostomy tube. (3) Intravenous feedings - special fluids and nutrients are administered directly into the blood stream. c. These alternate methods of feeding are performed by a licenced nurse. The nursing assistant should inform the charge nurse if any of the tubes become dislodged. d. In some cases, limited oral feeding is still continued for residents using these alternate feeding methods.
	6. Hydration - 1.5 hours 6.1 Importance of adequate fluid intake: a. Helps prevent constipation. b. Helps dilute wastes and flush out urinary system. c. Promotes skin elasticity. 6.2 To encourage a resident to drink fluids, offer small amounts frequently and let the resident have his preference of fluids. 6.3 Fluid Balance:
Identify how fluid balance is maintained.	a. Fluid balance is maintained when the amount of fluid taken in is near the same amount eliminated. b. The nursing assistant aides the resident in maintaining this balance.
Identify nursing assistant role in maintaining fluid intake.	c. Amount of water requirements vary -A resident shall be encouraged to drink at least 8 to 10 glasses of fluids each day unless restricted. d. The nursing assistant's role

OBJECTIVE	CONTENT
	in maintaining fluid intake - (1) Changing water at bedside at least once a shift (OLTC Regulation). (2) Water pitcher shall be placed within reach of resident. (3) Clean water glass or cup kept next to water pitcher. (4) Offer water to resident frequently. 6.4 Measuring and recording of fluid intake: a. Imbalances in fluid intake and output can result in severe fluid imbalances such as - (1) edema (water retention). (2) dehydration (excessive water loss). b. The intake and output (I&O) is frequently measured and recorded - (1) Intake includes everything taken in that is liquid at room temperature: -Water, tea, etc. -Jello, ice cream, etc. -Fluids given directly into a vein (IV). (2) Output includes all fluids lost: -Amount of urine eliminated. -Perspiration. -Blood. -Diarrhea. -Vomiting. c. Measuring and recording of urinary output (refer to item 4.1,e. in this section).
Demonstrate measuring and recording of fluid intake.	d. Measuring and recording of fluid intake - (refer to procedure #2 in the Appendix)
Define dehydration.	6.4 Dehydration: a. Is abnormal loss (depletion)

OBJECTIVE	CONTENT
	of body fluids. b. Can become a life threatening problem.
Identify signs and symptoms of dehydration.	c. Signs and symptoms to observe for and report to charge nurse - (1) Tongue becomes coated and thickened. (2) Eyes and mouth very dry. (3) Eyes sunken. (4) Lips cracked. (5) Skin "stands alone" when pulled up between thumb and forefingers. (6) Skin warm to touch. (7) Drowsiness. (8) May become suddenly confused. (9) Below normal amount of urine output. (10) Concentrated urine. (11) Weight loss. 6.5 Edema: a. Swelling - tissue contains too much fluid.
Identify signs and symptoms of edema.	b. Signs and symptoms - (1) Swelling/puffiness. (2) Sudden weight gain. (3) Shortness of breath, congested breathing. (4) Decrease in amount of urine output.
Identify ways to relieve edema.	c. Some ways to relieve edema - (1) Observe and release tight fitting clothes, shoes. (2) Elevate (feet and legs) lower extremities. (3) Frequent position changes. (4) Ambulate at intervals (if condition permits). (5) Measure intake and output accurately. (6) Elevate head of bed. 7. Skin Care - 1.5 hours 7.1 Skin care factors: a. Skin is the first line of defense against infection.

OBJECTIVE	CONTENT
	b. Skin assists in regulating body temperatures. c. Skin assists to remove body wastes (perspiration). d. Aging may cause changes in the skin - (1) Becomes scaly and dry. (2) Becomes delicate, thin and fragile (bruises and tears easily). (3) Wrinkles. (4) Loses its sensitivity to temperature changes and pain. (5) Becomes susceptible to decubiti (bedsores or pressure sores). e. A resident may not realize that a skin irritation is present due to loss of sensitivity . Therefore, check- (1) Bony prominences. (2) Scalp, head, neck, behind ears. (3) Skin folds. (4) Fingernails and toenails. (5) Change and color of skin.
List changes in skin condition that shall be reported to the charge nurse.	f. Observe and report changes in skin - (1) Redness. (2) Rashes. (3) Broken skin. (4) Tender places. (5) Blue areas. (6) Any changes in color or appearance.
	7.2 Decubitus ulcers (Bedsores/ Pressure sores):
Identify resident's skin changes which are signs and symptoms of a ducubitus ulcer.	a. Signs and symptoms - the resident's skin change will be - (1) Discolored: red, blue and/or white. (2) Warm. (3) Tender. (4) Painful. (5) Have feeling of burning. (6) Open as a sore. Damage may occur in underlying

Unit VI (contd.)

OBJECTIVE	CONTENT
Describe places to check on the body for a decubitus ulcer (pressure sore).	tissue before the skin breaks. Places to check on the body for a decubitus are the bony prominences, such as: (7) Shoulder blades. (8) Elbows. (9) Knees. (10) Ankles. (11) Backbone. (12) Behind ears. (13) Buttocks. (14) Hips. (15) Heels.
State reasons why the elderly are prone to skin problems.	b. Older people are more prone to development of decubitus - (1) Their skin is very easily damaged. (2) They may not have an adequate amount of tissue padding over their bones. (3) They need to be reminded to turn and encouraged to be up in the chair. c. Obese residents tend to get decubitus formation on areas where their body parts rub together. Places to check for formation of bedsores are the folds of body where skin touches skin.
List measures for preventing skin breakdown and decubitus.	7.3 Prevention of decubitus: a. Prevention is the responsibility of everyone involved in the resident's care. b. Observe skin daily and every time you reposition the resident for signs and symptoms of decubitus. c. Prevention involves removing causes - (1) Pressure: -Turn the resident often. Change his position at least every two hours (OLTC Regulation). -Don't leave a resident on a bedpan for a long time.

Unit VI (contd.)

OBJECTIVE	CONTENT
	-Keep bed linens or residents clothing free from wrinkles under his body. -Keep resident well hydrated.
Identify measures which help prevent decubitus ulcers.	(2) Shearing: -Lift, rather than slide, resident when positioning in bed or chair. (3) Irritation: -Keep resident's skin clean and dry. -Keep linen and clothing clean and dry. -Check incontinent residents frequently. -Clean up urine and feces immediately. (4) Poor circulation: -Lightly massage the bony prominences with lotion each time you turn a resident. d. Devices used in preventing pressure - (1) Sheep skin/foam pads for elbows and heels. (2) Flotation pad. (3) Water bed. (4) Alternating air mattress. (5) Air cushions. (6) Sponge rubber bed cushions.
	8. Transfers/Positioning/Turning - 3 hours 8.1 Lifting and moving:
Identify general principles for lifting and moving.	a. Principles - (1) Before procedure, explain it to resident. (2) Protect all tubing when moving someone. (3) Give most support to heaviest parts of the body. (4) Hold resident close to the body for best support.

OBJECTIVE	CONTENT
	(5) Use smooth, steady, not jerky motions. (6) Lock bed and chair wheels. (7) Raise bed when moving someone remaining in bed. (8) Use "draw" or turn sheet whenever possible. (9) Use transfer belt around resident's waist for safety.
Demonstrate ability to move resident: -Raise to sitting position. -Move toward head of bed. -Move to one side of bed. -Turn from side to side. -Transfer from bed to chair and chair to bed. -Transfer from bed to stretcher.	b. Demonstrate the ability to - (refer to procedures #14, 38, & 41 in the Appendix) (1) Raise resident to sitting position. (2) Move resident toward head of bed. (3) Slide helpless resident to one side of bed. (4) Turn resident from side to side. (5) Transfer nonambulatory resident from bed to wheelchair or chair. (6) Transfer from bed to stretcher.
Describe correct body alignment.	8.2 Body alignment: a. The correct positioning of the resident's body is referred to as body alignment. When a person's body is in correct body alignment - (1) Head is erect, not flexed forward nor extended backwards. (2) Vertebral column is in normal alignment. (3) The extremities are positioned according to the position of the resident. (4) Feet are in the "walking" position, not slanted forward. (5) The wrists are neither flexed or extended. (6) Fingers are slightly flexed.

OBJECTIVE	CONTENT
	(7) Hips are straight in line with the thighs. 8.3 Safety with wheelchairs and geriatric chairs: (refer to procedure #13 in the Appendix)
List the steps and demonstrate proper use of geriatric chairs and wheelchairs.	a. Resident shall be covered to protect from chilling. Blankets shall be kept away from wheels. Tuck the blanket firmly around the resident. b. The wheelchair or geriatric chair shall be wiped off with a disinfectant solution after each use, if it is to be used by others. c. Push the wheelchair from behind except when going in and out of elevators, pull the wheelchair into and out of the elevator backwards. d. If moving a resident down a ramp, take the wheelchair or geriatric chair down backwards. Glance over your shoulders to be sure of your direction and prevent collision and possible falls. e. Sets the brakes when - (1) Assisting a resident into a wheelchair or geriatric chair. (2) Assisting a resident out of a wheelchair or geriatric chair. (3) When the wheelchair or geriatric chair is to remain stationary. f. Put foot rests up when assisting resident in and out of wheelchairs or geriatric chairs. g. Have resident's feet on foot rests when moving. Never push the wheelchair if the foot rests are in an up position. h. If safety straps are needed

OBJECTIVE

CONTENT

they shall be fastened correctly. This may be considered a restraint, so follow accepted policy.

i. Observe the resident's feet when turning the wheelchair or geriatric chair or when going down corridors. Pay attention where you are going and push chair slowly.

j. Slow down at corners and LOOK before moving the wheelchair to prevent collisions with other residents, staff, etc.

k. Elderly residents depend on the nursing assistant for safety -
   (1) Never assume that corridors are empty.
   (2) Push the wheelchair or geriatric chair slowly to prevent accidents.

Identify and demonstrate measures of proper use of mechanical hydraulic lifts.

8.4 Hydraulic lifts:
(refer to procedure #48 in the Appendix)

a. Purpose -
   (1) Used for resident who cannot assist in transfer.
   (2) Used to move resident from bed to chair or into tub.

b. General safety rules -
   (1) The wheelchair to which the resident is to be moved is placed nearby.
   (2) Allow enough room for the lift to be turned.
   (3) Wheelchair brakes are locked.
   (4) Never operate a mechanical lift without the assistance of another staff person. Safety requires that at least two people are present.
   (5) LOCK ALL brakes after positioning lift.
   (6) Be sure that all locks

OBJECTIVE	CONTENT
	and straps are fastened securely before operating lift. (7) When resident is secured in straps or slings, raise them slowly. (8) One person guides the resident's legs in the direction to go. Be careful that their legs do not bump into any objects. (9) The other person moves the lift. (10) Reassure the resident while transferring. (11) Elderly people are very frightened about falling.
Identify and demonstrate safe and proper use of walkers, canes and crutches.	8.5 Safe use of walkers, canes and crutches: a. All devices shall have skid-proof tips. b. Residents should wear skid-proof shoes. c. Walkers - (1) Stand still. (2) Place walker forward with all four legs solidly on floor. (3) Step forward toward walker, repeat. d. Crutches - (1) Should have some space between top of crutch and axilla. (2) Arms should be completely extended. (3) Weight supported on palms of hands. e. Cane - (1) Plain care (one foot). (2) Quad cane (having four feet to put on the floor) is more stable than plain cane.
Identify and demonstrate steps to follow in assisting resident to walk.	8.6 Assist resident with walking: a. Resident should wear skid-proof shoes. b. When assisting a resident

Unit VI (contd.)

OBJECTIVE | CONTENT

from bed to walking, move resident slowly to avoid dizziness.

c. Assist on weak side.

d. Allow resident to use strong side for holding onto hand rails.

e. When assisting a visually impaired resident, walk slightly ahead, allow resident to hold nursing assistant's arm. Explain hazards in path as necessary.

f. Transfer belt may be used for safety.

9. Occupied Bed - 1 hour

9.1 Used for a resident who is unable to be out of bed.

9.2 Important facts and considerations:

a. To provide the resident with a clean, comfortable and dignified environment.

b. To prevent skin irratation and breakdown by providing clean, dry and wrinkle-free linens.

c. Is usually made after the resident's bed bath is completed.

Identify and demonstrate measures of making an occupied bed.

9.3 Measures of making an occupied bed:
(refer to procedure #46 in the Appendix)

a. Respect the resident's privacy -

(1) Knock before entering the room and wait for the resident's permission to enter.

(2) Identify yourself to the resident and what you plan to do.

(3) Use the resident's privacy curtain and do not expose the resident any more than is necessary.

OBJECTIVE	CONTENT
Demonstrate ability to make an occupied bed.	b. Much the same as the unoccupied bed (see Part I, Unit V) c. Bottom sheets are to be smooth, tight and wrinkle-free under the resident. d. Be constantly aware of infection control. e. Do not rush the procedure. f. Place signal cord or call bell within reach of the resident.
	10. Restraints - 1.5 hours
Give the purpose of restraints.	10.1 Purpose - for the protection of the resident to prevent injuries or interruption by the resident of needed treatments.
	10.2 Applied after other measures have been tried and documented only on physician's order:
Identify the length of time restraints may be applied.	a. Use is to be temporary. Not applied longer than 12 hours.
	b. To be applied properly.
Tell how frequently restraints are to be checked.	c. To be checked every 30 minutes.
	d. To be released every 2 hours and resident exercised for 10 minutes and resident's position changed.
Tell how frequently the restraints are to be released and for how long.	10.3 Types of restraints: a. Hand and foot restraints - (1) Used to keep a limb immobilized. (2) Wrist/ankle is padded with special felt pads. The cloth restraints are then applied by using a clove hitch (which will not tighten when pulled). The ends are then tied to the bed frame. NEVER attach a restraint to the side rails. b. Cross over jacket restraints (posey vest) -
Identify and describe the types of restraints.	(1) Are put on like a jacket. (2) Ends are crossed over in back or front (as directed by manufacturer).

Unit VI (contd.)

OBJECTIVE	CONTENT
	(3) Ends are tied behind wheel chair or on bed frame. c. Safety belts - (1) Locked restraints are not allowed (OLTC Regulation) (2) Belt goes around resident's waist. (3) Attaches to a longer belt which is fastened behind wheelchair or on bed frame. d. Mitt restraints - (1) Are used for confused residents who could harm themselves with their hands or fingers. (2) A mitt is similar to a paddle that encloses the hands. 10.4 Guidelines to follow in the application of restraints: (refer to procedure #10 in the Appendix)
Identify and demonstrate measures in the application of restraints.	a. Allow resident as much movement as possible but still serving the intended purpose. b. Resident's circulation shall not be occluded by the restraint. c. Pad bony points under a restraint in order to prevent trauma. d. The restraint shall be applied so that the resident's body is in a normal position. e. Use the least amount of restraint that will protect the resident. f. Never apply restraints without a direct order from charge nurse.
Identify symptoms of occlusion.	g. Check the resident's extremity every 30 minutes for the following symptoms of occlusion: pallor, blueness, cold, tingling, pain, pulses not present. If any of these symptoms are present, loosen

OBJECTIVE

CONTENT

restraints immediately and report to the charge nurse.

h. Remove restraints every two hours. Exercise for at least 10 minutes and provide skin care. Ambulate resident if possible. (OLTC Regulation).

i. Never apply a restraint without checking the resident's circulation before leaving the room. Pulses shall be felt. Loosen restraint if they are not felt.

j. Resident's medical record shall include: physician's order for restraint, reason for use, when applied and released, type of restraint, nursing care provided (OLTC Regulation).

10.5 PHYSICAL RESTRAINTS ARE NOT TO BE USED TO LIMIT RESIDENT MOBILITY FOR THE CONVENIENCE OF STAFF. If a resident' behavior is such that it will result in injury to self or others and any form of physical restraint is utilized, it should be in conjunction with a treatment procedure designed to modify the behavioral problems for which the resident is restrained or as a last resort, after failure of attempted therapy.

UNIT VII
Basic Nursing Skills
(10 hours theory/lab and 5 hours clinical)

OBJECTIVE	CONTENT
	1. Vital Signs - 7 hours
Identify why measuring vital signs are important as it relates to the nursing assistant.	1.1 Vital signs are the signs of life. Vital signs are the measurements of the function of the vital organs. Included in vital signs are temperature, pulse, respiration and blood pressure (T.P.R. and B.P.).
Describe what causes body temperature.	1.2 Temperature: a. Description - (1) Is a measurement of the amount of heat in the body, a balance between heat created and lost. (2) Is lost from the body to the environment by contact, perspiration, breathing and other means. (3) Is created as the body changes food to energy.
Define normal temperatures.	b. "Normal" or average temperature - (1) Oral - 98.6 degrees F (Fahrenheit). (2) Rectal - 99.6 degrees F. (3) Axillary - 97.6 degrees F. (4) Older people have a greater variation in normal range. One individual may have a usual temperature of 97 degrees F, another 99 degrees F. To determine deviations from "normal", it is helpful to know what is usual for that resident.
List situations that cause variations from "normal" temperature.	c. Variations from "normal" - (1) Some situations causing higher than normal readings are; eating warm food, time of day, infection or other

OBJECTIVE	CONTENT
	diseases, smoking, snuff or other tobacco use. (2) Situations causing lower readings; eating cold food, time of day, dry mouth, approaching death.
Define fever. Describe the signs and symptoms of below normal body temperature.	d. Fever - elevated body temperature - Signs/symptoms: (1) Warm skin. (2) Flushed color. (3) Chills/teeth chattering. (4) Eyes burning. (5) Confusion. (6) Skin moist as fever breaks.
Describe the signs and symptoms of below normal body temperature.	e. Below normal body temperature - Signs/symptoms: (1) Finger/toenails blush color. (2) Skin ashen color (grey/blue). (3) Cool/dry to touch.
Describe the types of thermometers.	f. Types of thermometers - (1) Glass - made of hollow glass tube containing mercury, has markings on outside for reading level. Types of glass thermometers: -slender tip - mercury-filled tip is longer and slender; used for oral or axillary checks. -stubby or safety tip - mercury filled tip is short and rounded; used for any temperature check (2) Electronic (battery powered) - has a probe which is covered with a disposable plastic

OBJECTIVE	CONTENT
	sheath before inserting. Temperature registers on a digital display. (3) Chemically treated paper - changes color to indicate reading. g. Care of thermometers - (1) Easily breakable. Handle with care. (2) Avoid hot water in cleansing. (3) Disinfect after each use, as specified by facility or accepted nursing text procedure. h. Method of checking temperature -
Identify and demonstrate measures of taking an oral temperature.	(1) Oral: -Used in most all situations, when not contraindicated. -Take per accepted procedure (refer to procedure #17 in the Appendix). -Stay with resident. **-Wash your hands.**
Identify and demonstrate measures of taking rectal temperature.	(2) Rectal: -Used when oral is contraindicate, is unsafe or inaccurate. -Resident cannot hold mouth closed around thermometer. -Resident's mouth is dry or inflamed. -Resident is a mouth breather. -Resident is comatose. -Resident is using oxygen. -Take per accepted procedure (refer to procedure #28 in the Appendix). -Stay with resident. **-Wash your hands.** (3) Axillary:

OBJECTIVE	CONTENT
Identify and demonstrate measures of taking an axillary temperature.	-Used when other methods are unsafe or inaccurate. -This is a less accurate measurement than other methods of checking temperature. -Place bulb of thermometer in center of armpit. -Take per accepted procedure (refer to procedure #5 in the Appendix). -Stay with resident, holding thermometer in place. -**Wash your hands.**
Identify how the nursing assistant should record and report temperature measurement.	i. Recording/Reporting/Cautions - (1) Mark chart with "R" (rectal) and "Ax" (axillary) for the method used in taking the temperature. (2) Notify charge nurse when: -Resident's temperature is above his normal range or has changed by more than 2 degrees from last measurement. -There is difficulty obtaining temperature.
Describe the cautions when taking a resident's temperature.	(3) Cautions: -When removing the glass thermometer/electronic thermometer probe covering, the sheath shall be removed and destroyed. -Stay with the resident, holding the thermometer in place. -If thermometer breaks in the resident's mouth or rectum, report immediately to charge nurse.

OBJECTIVE

CONTENT

-The glass thermometer shall register below 96 degrees F before taking a temperature.
-Ascertain that the electronic thermometer is fully charged and operable.

1.3 Pulse:
- a. Description - a measurement of the number of times the heart beats, a simple method of observing how the circulatory system is functioning.
- b. "Normal" or average pulse -
  - (1) 60 to 90 beats per minute for an older resident.
  - (2) Should be regular in rate, rhythm and strength or force.
- c. Variations in the pulse -
  - (1) Abnormal force:
    -Bounding pulse.
    -Feeble, weak and thready.
  - (2) Abnormal rate:
    -A pulse beat of under 60 beats for one full minute.
    -A pulse beat of over 90 beats for one full minute (exercise or activity normally cause a temporary increase in the pulse rate. Fever may increase the pulse rate).
  - (3) Abnormal rhythm:
    -Irregularity of beats.
    -Feeling like beats are being "skipped" when pulse is counted for one full minute.
- d. Common sites for checking pulse -
  - (1) Radial.

Unit VII (contd.)

OBJECTIVE	CONTENT
	(2) Apical. (3) Femoral. (4) Temporal. (5) Carotid.
Identify and demonstrate measures of taking the radial pulse.	e. Take per accepted procedure (refer to procedure #6 in the Appendix). f. Time - take pulse for one full minute. g. Recording and reporting - (1) Mark the chart with the symbol "Ap" when recording an apical pulse. (2) Notify the charge nurse when: -Pulse begins to show variations from "normal". -There is difficulty in obtaining pulse.
Identify what is meant by respiration and an average respiratory rate.	1.4 Respiration: a. Description - respiration is the inspiration (taking in) and expiration (letting out) of air. b. Average respiratory rate - 16-24 inspiration/expirations per one full minute for a resident.
Identify variations from normal respiration which should be reported.	c. Variations in respiration - (1) Rate: -Increased by exercise, fever, lung disease, heart disease. -Decreased by sleep, inactivity, pain medication. -Report rate greater than 28. -Report rate less than 12.
Identify character of respirations.	(2) Character: -Labored - difficulty breathing, extra muscles used for breathing. -Noisy - sounds of obstruction, wheezing gurgling.

OBJECTIVE	CONTENT
	-Shallow - small amounts of air exchanged. -Cheyenes-stokes - pause between labored/shallow respirations.
Demonstrate taking respiration rate.	(3) Take per accepted procedure (refer to procedure #7 in the Appendix)
	1.5 Blood pressure:
Define blood pressure.	a. Blood pressure is the force of blood against artery.
Describe blood pressure.	b. A description of blood pressure - (1) The rate of strength of heart beat. (2) The ease with which the blood flows through the blood vessels. (3) The amount of blood within the system.
	c. Terms -
Define systolic.	(1) Systolic pressure - the force when the heart is contracted; the top number of BP; the first sound heard when measuring BP.
Define diastolic pressure.	(2) Diastolic Pressure - the force when the heart is relaxed; the lower number of BP; the level of which pulse sounds change or cease.
Identify "normal" blood pressure range for systolic and diastolic blood pressure for an elderly resident.	d. "Normal" or average blood pressure range for an elderly resident is - (1) Systolic - 100 to 160 mmhg (mercury). (2) Diastolic - 60 to 90 mmhg.
	e. Variations in blood pressure - (1) Blood pressure may increase with age.
Define hypertension.	(2) Hypertension - blood pressure higher than normal.
Define hypotension.	(3) Hypotension - blood

OBJECTIVE	CONTENT
	pressure lower than normal.
Define postural hypotension.	(4) Postural hypotension - the elderly resident's body is unable to rapidly adjust to maintain normal blood pressure in the head and upper body when the resident moves from lying to standing, or sitting to standing. The resident will complain of dizziness or feeling faint.
Identify common causes of hypotension.	f. Common causes of hypotension- (1) Hemorrhage (loss of blood). (2) Shock. (3) Blood diseases.
Identify common causes of hypertension.	g. Common causes of hypertension - (1) Narrowing and hardening of the arteries. (2) Rupture of blood vessels in the brain (stroke). (3) Aged resident. (4) Overweight (obesity). (5) Kidney disorders.
Identify instruments to check blood pressure.	h. Instruments for checking blood pressure - (1) Sphygomanometer (blood pressure cuff and gauge). (2) Stethoscope.
Identify and demonstrate measures of taking blood pressure.	i. Procedure for taking blood pressure - (refer to procedure #29 in the Appendix) (1) Choose a cuff appropriate size for the resident's arm. (2) Position cuff on upper arm and position gauge for accurate reading.
Identify how to record and report blood pressure	j. Recording and reporting - (1) Record - systolic over diastolic (e.g. 120/80)

OBJECTIVE	CONTENT
	(2) Notify charge nurse when a resident's blood pressure is higher or lower than his normal range. (3) Difficulty in obtaining the blood pressure. 1.6 Height and Weight (refer to procedure #4 in the Appendix).
Identify and demonstrate height measurement: -for the bedfast resident. -for the ambulatory resident.	a. Height - (1) Explain to the resident what you are going to do. (2) Wash your hands. (3) Have resident stand with arms to the side. (4) Make sure resident is standing as straight as possible. (5) Measure from top of head to bottom of feet. (6) If resident is unable to stand, have resident lie flat in bed and measure from head to feet. (7) Record height on paper and report to the nurse.
Identify importance of body weight.	b. Weight - (1) Importance: -Indicates nutritional status. -Weight loss/gain indicates change in medical condition.
Be able to explain accurate measurements and variance.	(2) Accurate measurements shall be taken: -If weight varies more than 5 pounds, verify accuracy of weight and report to charge nurse.
	(3) Types of scales: -Wheelchair. -Bedscales. -Standing scales. -Scales attached to hydraulic lifts. -Bathroom scales.
Identify and demonstrate measures for weighing.	(4) Procedure for weighing (refer to procedure #4

OBJECTIVE	CONTENT
	in the Appendix).
Identify when weights are taken.	(5) Weight taken: -On admission (OLTC Regulation). -Once a month unless ordered more often by physician (OLTC Regulation).
List some attitudes and actions which are prerequisites for making observations about residents.	2. Recognizing and Reporting Abnormal Changes (1 hour) 2.1 Attitudes and actions prerequisite to making observation about residents: a. Making observations is continuous during resident care. b. Be alert at all times. c. Use senses to observe - (1) See changes such as skin rash or edema. (2) Feel changes such as fever or change in pulse. (3) Hear changes such as changes in breathing sounds. Listen to resident complaints. (4) Smell odor of urine.
	2.2 Recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor. Some examples of abnormal changes are: a. Shortness of breath. b. Rapid respiration. c. Fever. d. Coughs. e. Chills. f. Pains in chest. g. Blue color to lips. h. Pain in abdomen. i. Nausea. j. Vomiting. k. Drowsiness. l. Excessive thirst. m. Sweating. n. Pus. o. Blood or sediment in urine.

OBJECTIVE	CONTENT
	p. Difficulty urinating. q. Frequent urination in small amounts. r. Pain or burning during urination. s. Urine has dark color or strong odor. 2.3 Reporting observations: a. Changes in resident's condition should be reported to charge nurse. b. The nursing assistant is encouraged to recall the observation of what was actually seen, heard, felt, rather than the interpretation of these observations. 2.4 Some of the more common diseases: a. Alzheimer's Disease -
Define Alzheimer's Disease.	(1) Progressive, age related brain disease that impairs thinking and behavior. (2) Causes decline in intellectual functions and ability to perform routine activities. (3) Disease has gradual onset and resident may experience confusion, personality change, impaired judgement and difficulty finding words, finishing thoughts or following directions. (4) Eventually the resident becomes totally unable to care for themselves.
Recognize that there are changes in the brain caused by Alzheimer's.	(5) Changes in the brain are: -Senile plagues. -Neurofibraillary tangles in those areas of the brain responsible for memory and intellectual functions.

OBJECTIVE	CONTENT
	-Lack of brain chemical acetylcholine which is involved in the processing of memory by the brain. (6) There is no treatment available to stop or reverse the mental deterioration of Alzheimer's Disease. b. Diabetes Mellitus -
Define Diabetis.	(1) Diabetes is the result of the body's inability to break down and use carbohydrates (starches and sugars) to nourish the body cells in the production of insulin.
Identify the purpose and use of insulin.	(2) Insulin is the hormone that produces the amount of glucose to be secreted into the blood stream to nourish the body cells. (3) If the body does not produce insulin, glucose builds up in the blood stream (hyperglycemia) and the cells cannot be nourished. The glucose spills out through the kidney into the urine (glycosuria). (4) The cells begin to use fats for metabolism. When fat is used too much a by-product (acetone) is excreted. Acetone is a type of ketone and when there are too many ketones in the body, it is excreted through the kidney. When the acetone/ketone level is very high the body is unable to excrete poison toxic substances causing

OBJECTIVE	CONTENT
	acidosis. Coma and death are a result of severe acidosis. (5) Symptoms to report to nurse in charge; hunger, nervousness, weakness, headache, sweating, drowsiness, blurred vision, tingling sensations, stupor, death, thirst, increase in urine, nausea, vomiting, abdominal pain, slow mental response, flushed face, dry skin, sweet breath.
Discuss the respiratory conditions which prevent the intake of sufficient oxygen.	c. Respiratory Diseases - (1) Conditions which interfere with breathing and prevent the intake of sufficient oxygen. (2) Causes of problem are; Emphysemia, cancer, colds and flu, pneumonia, muscle weakness, changes in lungs, tuberculosis. (3) Symptoms; shortness of breath, wheezing, tightening and raising of shoulders, respiration faster and more shallow breathing, coughing, bluish or grayish skin color. (4) Report any symptoms to the charge nurse.
Identify nursing assistant responsibility in caring for resident with a stroke.	d. Cerebrovascular Accident (CVA) - (1) A "stroke" is caused by; bleeding in the brain, blood clot in the brain, partially blocked blood vessel in the brain that impair the circulation of blood. (2) Symptoms; changes in

Unit VII (contd.)

OBJECTIVE	CONTENT
	vital signs, impaired memory, speech difficulty, changes in behavior, paralysis of part of the body, incontinence, difficulty swallowing, mental confusion, loss of sensitivity, balance impairment. (3) Care is to prevent complications, injury, provide safety and to restore maximum amount of independence: physically, mentally, and emotionally.
Define fracture.	e. Fractures - (1) Break in a bone. (2) Symptoms; loss of strength and movement, pain, tenderness over break area, bruising and swelling, deformity or misaligned body position. (3) Stay with resident. DO NOT MOVE RESIDENT. Call charge nurse when appropriate. Need to insure patient has adequate intake of fluids even though patient does not express "being thirsty."
Define AIDS. Identify modes of transmission of AIDS.	f. Acquired Immune Deficiency Syndrome (AIDS) - (1) AIDS is a body fluid and sexually transmitted disease in which a virus invades the body, damages the immune system, and allows other infectious agent to invade the body and cause death. (2) ARC (AIDS Related Complex) refers to a variety of conditions

OBJECTIVE	CONTENT
	caused by secondary infections related to AIDS. (3) AIDS/ARC is caused by the Human Immune Deficiency Virus (HIV) (4) Transmission: -Spread through body fluids, primarily blood and semen. -All body fluids and tissues should be regarded as potentially infectious. -AIDS is transmitted by sexual contact, by needle sharing, and through contaminated blood products. (5) Symptoms; may have no symptoms, may have AIDS Related Complex, enlarged lymph nodes, fungal infection of mouth accompanied by fatigue, weight loss.
Identify nursing assistants responsibilities in caring of the resident with heart disease.	g. Heart Disease - (1) Is the leading cause of death in the elderly. (2) Muscles of the heart do not pump as well. (3) The vessels leading to the heart become narrow. (4) Symptoms; changes in blood pressure, perspiration and weakness, pale, clammy skin, kidney output decreases, ankles and feet may swell, nail beds may turn blue. (5) Nursing assistant responsibilities: -Follow directions of charge nurse. -Make resident as comfortable as possible.

OBJECTIVE	CONTENT
	-Rest periods should be encouraged. -Help keep environment quiet. -Position residents to help breath easier.
Identify society's attitude about death.	3. Death and Dying (1 hour) 3.1 Stages of reaction to dying: a. DENIAL - denying that death will occur -
Describe stages of reaction to dying.	(1) Behaviors: -Unrealistically cheerful. -Ask lots of questions. -Disregard medical orders. (2) Response to this behavior: -Listen, be accepting. -Do not probe. b. ANGER - anger that this is happening to me, and anger at others because it is not happening to them - (1) Behaviors: -Complaining. -Unreasonable requests. -Anger at family, doctor, nursing staff. (2) Response to this behavior: -Listen. -Remain open and calm. -Don't try to place blame. c. BARGAINING - trying to make an agreement for postponing death - (1) Behaviors: -May be difficult to observe this stage. -Person vacillates between doubt and hope. (2) Response to this behavior: -Listen. -Do not contradict plans.

OBJECTIVE	CONTENT
	-Promote a sense of hope. d. DEPRESSION - reality of death is unavoidable; is a reaction to getting sicker; and is grieving for the losses they will experience - (1) Behaviors: -Turn face away from people. -Not speak or speaks in expressionless voice. -Separating self from the world. (2) Response to behaviors: -Stay with the person as much as is possible. -Avoid cheery phrases and behavior. -Encourage the person to express feelings. e. ACCEPTANCE - realizes that death is inevitable.
	3.2 Physical care of the dying resident:
Identify approaches to physical care of the dying resident.	a. Physical care to meet the resident's needs continues to the person's death. b. Provide for keeping resident warm. c. Keep room well-lighted since vision diminishes. d. Provide for skin cleanliness due to perspiration and perhaps incontinence. e. Change position at least every 2 hours unless contraindicated. f. Give special attention to mouth care and take measures to moisten mouth to promote comfort. g. Speak to the resident in a normal voice. Assume that they can hear you even if they appear unconscious and speak accordingly.

OBJECTIVE	CONTENT
	h. Provide for spiritual support, respecting the resident's personal wishes and not imposing one's own beliefs. i. Communicate through touch if the person appears unconscious.
Identify and demonstrate measures of post mortem care.	3.3 Post mortem care: (refer to procedure #37 in the Appendix) a. Meaning - caring for the body of the deceased. b. When a person dies, their physician is called to certify the death. c. The purpose for much of the post mortem care which is done is to prepare the body for reviewing at the funeral. d. How much is done by nursing home personnel depends on the local situation. If mortuary personnel pick up the body soon after death, care provided by the nursing home may consist of only - (1) Place body in supine position. (2) Remove tubes, replace soiled dressings. (3) Account for what is done with or to whom personal effects are given. (4) Follow facilities policy and procedures.
	4. Admission/Transfer/Discharge (1 hr.) 4.1 Admission: a. Before admission - (1) Check the unit tc insure furniture is present and in good condition. (2) Make sure that necessary equipment is available. b. Feelings of resident/family -

OBJECTIVE	CONTENT
Identify feelings of resident/family on admission of resident.	(1) May be acutely aware of losses experienced with aging and illness. (2) Resident may feel lonely, lost, confused or relieved. (3) Family may experience guilt.
Identify and demonstrate responsibilities of the nursing assistant during the admission of a resident.	c. Responsibilities of the nursing assistant during admission - (refer to procedure #33 in the Appendix) (1) Greet the resident/family Call the resident by proper name or the name the resident prefers. (2) Introduce yourself to the resident/family giving your name and position. Be courteous and friendly. REMEMBER, first impressions are often lasting impressions. (3) Show the resident the room, bathroom and how to use the call bell. (4) Assist in unpacking clothing and belongings. (5) All items are to be properly labeled according to a policy of a facility. (6) Follow an approved procedure regarding inventory list of valuables, possessions, and clothing. (7) Give instructions as to time and place of meals. (8) Orient the resident/family to the facility. (9) Introduce resident/family to other residents and staff. (10) Make sure that the resident is comfortable. Check on the resident frequently.

OBJECTIVE	CONTENT
Identify asnd demonstrate the responsibilities of the nursing assistant on transfer/discharge of a resident.	4.2 Transfer/Discharge: (refer to procedure #30 in the Appendix) a. Transfer/discharge arrangements are made by the attending physician and administration. b. The nursing assistant shall allow the resident to talk about anxieties and shall make every effort to insure the change is easy and pleasant. c. The nursing assistant shall be sure that all personal clothes and belongings are sent with the resident. d. When appropriate, the nursing assistant shall complete and sign inventory forms and transfer/discharge forms. e. Following the resident's discharge the room shall receive a thorough cleaning.

Unit VIII
Social/Cognitive/Behavioral
(5 hours theory/classroom lab)

OBJECTIVE	CONTENT
	1. Cognitive (Mental Functions)
Define the term cognitive as it relates to the responsibility of the nursing assistant.	1.1 Cognitive (Mental) Achievements: a. Memory and orientation. b. Immediate recall. c. Memory for recent and remote events. d. Orientation in time, place, and person. e. Concentration and good judgment. f. Current social and physical performance. g. Insight and judgments excellent.
Define cognitive functions as it refers to mental process of the resident.	1.2 Cognitive (Mental) Impairments: a. Comprehension. b. Judgments. c. Memory. d. Reasoning.
Identify the various mental abilities as it relates to level of consciousness, orientation, intellectual capacity.	1.3 The various mental abilities do not decline at the same rate of speed: a. Level of consciousness - (1) The resident alert and quick to respond. (2) The resident drowsy and slow to respond. (3) The resident semiconscious and difficult to arouse. (4) The resident comatose and unable to respond. b. Orientation - (1) The resident alert to time, to place, to person. (2) The resident does not pay attention or understand when someone else is talking. (3) The resident wanders about, not oriented to place. (4) The resident is not knowing of self and others. c. Intellectual Capacity -

Unit VIII (contd.)

OBJECTIVE	CONTENT
	(1) The nursing assistant should recognize factors which may block resident's intellectual abilities. (2) The nursing assistant must be patient. The resident will most likely respond to kindness. (3) The nursing assistant must use a tone of voice that carries respect for the resident.
Identify factors which affect the resident's ability to recall, understand, for self awareness and judgment.	d. Ability to recall - (1) Events recent and past. (2) Attention span short. (3) Attention span normal. e. Ability to understand - (1) Ideas. (2) Planned daily activities. (3) Slow to follow planned daily activities. (4) Unable to follow planned daily activities. f. Level of ability to understand - (1) Quick to understand and make friendly relationships with others. (2) Slow to understand and to make friendly relationships with others. g. Self-awareness - (1) Has insight into own health problems. (2) Little or no insight into own health problems. h. Judgment - (1) Resident's ability to concentrate and make reasonable and appropriate decisions. (2) Selecting clothes to wear. (3) Taking part in care plan. (4) Expresses desires and needs as to individual resident's rights of long term care facility.

Unit VIII (contd.)

OBJECTIVE	CONTENT
	i. Resident's ability to understand the rules and regulations of the long term care facility.
List factors which affect memory and reasoning of the resident.	1.4 Memory: a. Mental registration, mental retention, mental recall of past experiences of - (1) Knowledge. (2) Ideas. (3) Sensations. (4) Thoughts. b. Forgetfulness is a normal process of aging. 1.5 Reasoning: the ability to think and/or respond and/or make choices.
Identify factors which affect cognitive impairments of the resident.	1.6 Cognitive Impairments: a. Factors which influence are - (1) Reactions to stress. (2) Progressive loss of brain cells. (3) Poor nutrition. (4) Interactions of medications. (5) Alcoholism. (6) Strokes. (7) Other diseases and/or disorders.
Define behavior as it relates to the residents.	2. Behavior 2.1 Behavior is defined as: a. Ability to adapt and adjust. b. To behave appropriately in situations. c. To behave in accordance with culturally approved standards. d. Satisfactions are achieved through love, work, and interpersonal relationships.
List factors which influence behavior of the resident.	2.2 Factors which influence behavior: a. Attitudes. b. Past and present experiences. c. Illness. d. Fever. e. Loss of self-confidence.

OBJECTIVE	CONTENT
Identify ways in which the resident may express feelings through their behavior.	2.3 Appearance and behavior: a. Dress, posture, facial expression. b. Motor activity such as - (1) Agitation. (2) Impulse mannerism. (3) Retardation.
Identify factors which affect the residents thought process.	2.4 Thought process - When any of these thought processes are observed, they should be reported to the charge nurse: (a) Stream of talk. (b) Impairment of thought process. (c) Pace and progression of speech. (d) Whether the speech is logical and to the point. (e) Whether the speech is confusing and irrelevant. (f) Whether there is a presence of thought disorder such as flight of ideas or obsessive thoughts.
	3. Cognitive/Behavior Improvements
Identify observations to be made during care of the confused or withdrawn resident.	3.1 Caring for the confused or withdrawn resident: a. Symptoms of confusion - (1) Not knowing self or others. (2) Talking incoherently. (3) Forgetful. (4) Not paying attention or understanding when someone is speaking. (5) Sleep disorders. (6) Hallucinate, visual and auditory. (7) Wanders about, not oriented to place. (8) Combative, hostile. b. Symptoms of Pshco-social impairments - (1) Frightened, unhappy, bewildered. (2) Unaware of environment; thus, does not sense danger.

Unit VIII (contd.)

OBJECTIVE	CONTENT
	(3) Reduced intellectual and emotional contact with others. (4) Loss of self-expression. (5) Loss of independence. (6) Insecurity.
List medical problems related to the residents care.	3.2 Possible causes of confusion: a. Medical problems including - (1) Chronic disease, such as heart, liver, kidney, and lung problems. (2) Stresses such as surgery or injury. (3) Degenerative brain conditions such as Alzheimer's Disease. (4) Arteriosclerosis. b. Poor nutrition. c. Medication - (1) Older people may not tolerate drugs as well. (2) Combination of drugs may cause confusion. 3.3 Causes of withdrawal: a. Losses, including sight and hearing. b. Depression. c. Mental illness. d. Confusion.
Identify the purpose of reality orientation of the resident.	3.4 Therapies for confusion and withdrawal: a. Reality orientation (R.O.). b. Purpose - to maintain reality contact and halt or reverse confusion or withdrawal.
List the responsibilities of nursing assistant in the reality orientation for residents.	c. Technique - (1) Consistent, constant (all 3 shifts) 24 hour repetition of information about person, place, time expectations. (2) Aids such as calendars, clocks, information boards can be used. (3) Reality orientation: -Introduce yourself upon entering a resident's room. -Explain what you are

OBJECTIVE	CONTENT
	doing in the room. -Tell the resident the date, time and place. -Frequently ask the resident the date, time and place. -Ask the resident who he/she is and family members names, etc.
Identify the nursing assistants role in response to the residents combativeness.	3.5 Responses to combativeness: a. Use non-threatening approach. b. Give recognition to feelings behind behavior. c. Request directions from charge nurse for proper plan of care. d. When approaching combative resident, go with enough assistance to complete procedure. e. If resident suddenly becomes combative, call for help, IMMEDIATELY. f. Do not try to physically restrain a combative resident by yourself. g. Report to charge nurse.
Define the purpose of the remotivation program for the resident.	3.6 Remotivation: a. Purpose - (1) Prevent withdrawal. (2) Increase interest in reality. (3) Stimulate thinking. (4) Participate/perform activities of daily living (ADL's).
	3.7 Reminiscing: a. The resident has the right to reminisce about his/her life and to share feelings about the past, to promote feelings of worth and to reduce feelings of loneliness.
	4. Understanding and Managing Behavioral Symptoms of Alzheimer's Disease and Related Disorders 4.1 Social Facade: a. Description -

OBJECTIVE	CONTENT

- (1) Ability of the resident to look "not sick".
- (2) Ability of the resident to make casual conversation or general comments based on well ingrained memories.
- (3) While not looking ill, apparent energy can fool a casual observer.

b. Approaches -
- (1) Build on any and all attempts to have adult conversation with the resident.
- (2) Never remind the resident that self care is not possible.
- (3) Keep your conversation with the resident brief and pleasant.
- (4) Introduce the resident with a remark that calls upon the resident's past or present experience or interest.

4.2 Depression/Apathy/Withdrawal:

a. Description -
- (1) Depression must last awhile, be fairly severe, and not be a grief reaction after the death of a loved one.
- (2) Older people may withdraw, appear listless or restless, have difficulty concentrating, not feel life is worth living.
- (3) Depression is sometimes different in older persons.
- (4) Alzheimer's residents function even more poorly than others who are depressed.

b. Approaches -
- (1) If resident is sad and withdrawn, are there certain things that cheer

OBJECTIVE

CONTENT

the resident up?

(2) Alert the doctor or nurse.

(3) Spend special time with just the resident.

(4) Reassure the resident of the resident's value as a person.

(5) Reassure the resident that he/she will be cared for.

(6) A special relationship with a staff person, favorite family visitor or a minister can relieve depression.

(7) Respect the resident's right to feel sad and give reassurance that you're there to help the resident to feel better.

(8) It's wise to remove potentially dangerous objects and check the resident more frequently.

4.3 Rummaging, Pillaging, and Hoarding:

a. Description -

(1) Many Alzheimer's residents seem to be driven to search for something which they believe is "missing".

(2) The resident has lost the ability to tell the difference between things that belong and things that are out of place.

(3) Alzheimer's residents often lose memory of good manners. May enter a room without knocking or take their clothes off in public.

(4) The resident believes things are taken away from him/her.

(5) It is hard for the resident to tell which

OBJECTIVE	CONTENT

bed is his/her so will sometimes enter the wrong bed.

b. Approaches -
   (1) Best strategies are preventive.
   (2) Try to keep the resident occupied with a drawer of his/her belongings.
   (3) Don't give moral judgment or rational explanations to the resident.
   (4) Distract the resident if he/she is in someone else's room by asking them if they want to go see TV, etc.
   (5) Learn the resident's favorite hiding place.
   (6) Persuade the resident that their chair is more comfortable if he/she keeps sitting in the wrong chair or bed.
   (7) Wandering may be part of a search for the bathroom.

4.4 Wandering:
   a. Description -
      (1) There are more theories and proposed solution about wandering in dementia residents than any other symptoms of the disease.
      (2) Wandering has major implications for the family, facility and the community.
      (3) Some professionals see wandering as an expression of aimlessness, excessive restlessness, or the need for self stimulation that comes from brain damaging illness.
   b. Approaches -
      (1) See if the resident is hungry, feels uncomfort-

OBJECTIVE	CONTENT
	able, needs to void, or is genuinely lost. (2) Removing from view, shoes, coat and suitcase may remove the immediate idea of the desire to "leave". (3) Try to keep the resident busy and in view of the staff. (4) Placing a picture on resident's door may help the resident to locate his/her room. (5) Avoid putting the resident in close, crowded situation where he/she may experience stress and confusion. (6) Give the resident something to occupy his/her time. (7) If the resident wanders away from the facility, approach the resident calmly and reassure him/her. Do not interrogate the resident. 4.5 Suspiciousness: a. Description - (1) Resident experiences more and more difficulty making sense of their experience and environment. (2) Residents are suspicious because it is hard for them to accept the fact that they forget where they put things. (3) The dementia resident feels victimized by something that robs him/her of his/her previous well being. (4) Whispering between staff or family and staff is interpreted as a plot to steal their money, power,

OBJECTIVE

CONTENT

influence or possessions.

- b. Approaches -
  - (1) Don't argue or rationally explain disappearances. This only makes the resident feel stupid. Arguing only backs the resident into a corner, making him/her more insistent.

4.6 Delusions:

- a. Description -
  - (1) Delusions are fixed or persistent beliefs of the resident that remain despite all rational evidence to the contrary.
  - (2) Delusions can be frustrating or frightening to the resident.
  - (3) Some delusions are harmless and can be ignored or glossed over.
  - (4) Some delusions are based on real possibilities.
- b. Approaches -
  - (1) Try to judge how much the delusion bothers the resident.
  - (2) Don't use rational explanations to convince the resident that a delusion is incorrect.
  - (3) Reassure the resident and try to divert him/her to a less stressful subject.

4.7 Hallucinations:

- a. Descriptions -
  - (1) Hallucinations are sensory experience (seeing, hearing, or feeling) which can't be verified by anyone else.
  - (2) Seeing or hearing things is common in adults with brain disorders.
  - (3) Symptoms may be worse if the resident has visual or hearing defects.

OBJECTIVE

CONTENT

b. Approaches -
  (1) If the resident is not too upset or disturbed by the hallucination then the resident can usually be diverted or distracted.
  (2) Frightening hallucinations especially if resulting from dream states usually subside in the well lighted company of others with plenty of attention and reassurance.
  (3) Anti-psychotic medication may be ordered in instances where the resident believes bugs are crawling on him/her or is in his/her food.
  (4) Residents with frightening hallucinations are best reassured by someone they trust.

4.8 Catastrophic Reactions:

a. Description -
  (1) Catastrophic reactions is a term describing the behavior of a dementia patient when a situation overwhelms his/her ability to think and react.
  (2) Behavior may be any of the following: suddenly changing mood, crying inconsolably for a long time, anger, increasing suspicious, increasing restlessness, pacing, wondering off, combativeness, stubbornness, and worry or tension.
  (3) The resident appears stubborn, overly critical or overly emotional, all out of proportion to what has actually happened.

OBJECTIVE CONTENT

(4) Reactions can be set off by a number of things: several questions being asked at once, being asked "why" questions, feeling lost, small accidents, too many people in a new place, being scolded or contradicted, having an argument, staff members that are tense, rushed or impatient, and if a patient tries and fails to complete a task he/she once regarded as simple.

(5) Dementia residents experience a loss of impulse control.

(6) The resident loses adult judgment.

(7) The resident is unable to evaluate the seriousness of an incident therefore he/she "over-reacts".

b. Approaches -

(1) Try to head off or prevent situations that lead to catastrophic reaction.

(2) Give directions one step at a time.

(3) Using a rocking motion, patting, holding hands or soothing music to calm the resident.

(4) Distract the resident gradually with something new.

(5) Allow the resident plenty of space during a catastrophic reactions. Move slowly and tell the resident exactly what you are doing.

(6) Don't force a resident to spend time with someone that frightens or upsets him/her today because tomorrow may be a whole

OBJECTIVE CONTENT

different story.

(7) Don't take attacks personally. Attacks usually take place on whomever is closest.

4.9 Sundowning:

a. Description -

(1) Persons with acute or chronic confusion become more confused, restless and insecure late in the day and especially after dark.

(2) Attention span and concentration become even more limiting.

(3) No one knows what causes sundowning.

(4) Patients with Alzheimer's tire more easily, even from minimal demands on their thinking ability, and become more restless and hard to manage when tired.

(5) Sundowning may relate to a lack in sensory stimulation and the absence of routine daytime noises and dim lighting may trigger the Sundown behavior.

(6) Alzheimer's residents may become more anxious late in the day because they think they should be "going home" (all those feelings indicate a need for security and protection).

b. Approaches -

(1) An early afternoon rest may help if sundowning is caused by fatigue.

(2) Keep the resident active in the morning.

(3) Don't physically restrain the resident.

(4) Let the resident pace

OBJECTIVE

CONTENT

back and forth where he/she can be watched.
- (5) Give the resident something to fiddle within his/her hands to distract him/her.
- (6) Don't ask the resident to make decisions.

4.10 Inappropriate Behavior:
- a. Description -
  - (1) Loss of impulse control seen in brain diseases means infantile behaviors reappear.
  - (2) Has nothing to do with success or failure of childhood discipline or training.
  - (3) Resident may lose awareness that his/her behavior is not considered proper in public.
  - (4) Time sense is severely affected and the resident becomes intolerable to even slight delays.
- b. Approaches -
  - (1) Resident's tactless insults don't necessarily mean displeasure with on person but rather he/she is upset with his/her situation and the lack of control.
  - (2) Ignore insults or cursing of the resident.
  - (3) Reassure the resident that you won't leave and that the doctor told you how to take care of him/her.
  - (4) Childish patients who exhibit attention getting behavior may be craving more stimulation and will respond to a hug, pat or the chance to move around a little.
  - (5) Don't over react to

OBJECTIVE

CONTENT

incidents.

5. Social Care

List the basic human needs described.

5.1 There are five basic human needs which each individual needs are to be nurtured, accepted, loved and assisted to reach their highest potential (see Maslow's chart in Appendix):

a. 1st level -
   (1) Food.
   (2) Air.
   (3) Water.
   (4) Activities.
   (5) Sleep.
   (6) Physiological survival.
   (7) Need.

b. 2nd level -
   (1) Protection from harm.
   (2) Violence.
   (3) Disease.
   (4) War.
   (5) Poverty.
   (6) Assurance of continuing income and employment security.
   (7) Safety needs.

c. 3rd level -
   (1) Love.
   (2) Accepted by others.
   (3) Approval.
   (4) Membership in group.
   (5) Belonging.
   (6) Social need.

d. 4th level -
   (1) Worth.
   (2) Status.
   (3) Power.
   (4) Recognition.
   (5) Self-confidence-esteem.
   (6) Ego needs.

e. 5th level -
   (1) Full potential.
   (2) Creativity.
   (3) Self-actualizing needs.

List the emotional needs of the resident in a long term care facility.

5.2 Meeting emotional needs of the resident in a long term care facility:

a. Independence -

OBJECTIVE CONTENT

(1) Encourage decision-making in areas about which there can be a choice; foods when there is a selection, activities, when to do activities of daily living.

(2) Encourage resident to be in control of his own body; self-care as is possible, choice of clothing.

b. Need for supportive environment -

(1) Supportive physical environment:
- Proper medical and dental care.
- Safe, comfortable clothing.
- Room and halls free of accident-causing situations.
- Protection from others.

c. Need for social interaction -

(1) Encourage contact between residents and persons outside facility.

(2) Encourage interaction among residents.

(3) Keep charge nurse informed of expressed needs or wants of resident.

(4) Encourage resident to do as much as he can as well as he can for as long as he can.

(5) Encourage resident to maintain sense of belonging and self-esteem.

(6) Insure resident does not become isolated or withdrawn from others by establishing rapport and becoming acquainted.

(7) Promote interaction among other residents.

d. Need for recognition as an individual -

OBJECTIVE	CONTENT
	(1) Be respectful of each resident and allow for as much privacy as is possible. (2) Encourage self-expression in crafts, listening to their stories, recognizing past accomplishments. e. Spiritual needs - (1) Encourage and help resident to participate in spiritual observances. (2) Encourage and facilitate visits by clergy, if desired. (3) Respect individual beliefs; don't impose your own beliefs on residents.
Identify ways to help the resident's meet their needs status.	f. Status needs - (1) Speak to the resident by proper name and title. (2) Listen to their memories and fears. (3) Recognize residents past experiences. (4) Remind resident to be proud and feel important. (5) Discuss current events, ask their opinion.
Identify the aspects of sexuality in the aging.	5.3 Social aspects of sexuality in the aging: a. Sexuality fulfills strong needs for elderly in close relationship to another. b. Sexuality is part of a person's individuality. c. There is continued need among the elderly for respect and privacy in sexual matters. d. Individuals should be protected from unwanted advances of others and from embarrassing themselves if confused. e. Masturbation - allow privacy and don't interfere with this. However, if it occurs in public, it should be

OBJECTIVE	CONTENT
	managed in a sensitive way to prevent offending others and degrading the individual. The nursing assistant should inform the charge nurse of this type of occurence.

Unit IX
Basic Restorative Services
(5 hours theory/lab and 4 hours clinical)

OBJECTIVE	CONTENT
	1. Restorative Care - 1 hour
Define Restorative Care.	1.1 Restorative care involves the rehabilitation of the individual to the greatest personal, social, economical usefulness and independence of which the resident is capable:
Identify requirements of restorative care.	a. Restorative care requires the development of a fine degree of judgment to know when and when not to intervene. It is important to know how to intervene without the resident feeling he has failed. b. The maintenance of physical, mental and social functional abilities and capabilities require their constant use. The effects of inactivity becomes apparent within a few days and compounds the disabilities that result from injury or illness.
Identify changes in functional abilities associated with aging.	1.2 Residents awareness of changes of functional ability associated with aging: a. Becomes aware of using stair railings. b. Becomes aware of pausing before stepping off a curb. c. Becomes aware of stopping part of the way up a flight of steps. d. Becomes aware of the need for reading glasses or bifocals. e. Becomes aware that a whole day spent with children, friends, or relatives is tiring. f. Becomes aware that behavior that once was accepted is now irritating. g. Adoption to illness, emotional or social crisis become difficult.

Unit IX (contd.)

OBJECTIVE	CONTENT
Identify approaches to restorative care.	1.3 Approaches to restorative nursing care: a. Efforts directed to assist each resident to - (1) Express how he feels about his illness, himself, his behavior, and wants. (2) Become as independent as possible in Activities of Daily Living (ADL). (3) Prevent complications of illness or injury. (4) Learn new skills. (5) Develop a sense of personal accomplishment, usefulness, and pride. (6) Learn to accept the accomplishment of small goals because total rehabilitation may not be possible. (7) Remember skills are acquired.
List approaches to restoring resident's independence.	b. Approaches to restore resident's independence - (1) Be patient and give the resident plenty of time to do for himself. (2) Express confidence in his ability to be independent. (3) Emphasize the progress the resident makes. (4) Offer verbal praise for the residents efforts to do things for himself.
List physical measures of restorative care.	1.4 Measures of restorative care: a. Physical measure - (1) Proper body alignment. (2) Bed/Chair positioning. (3) Range of motion exercise. (4) Bowel and Bladder training. (5) Ambulation. (6) Elevation of extremities as indicated.
Name mechanical devices used in restorative care.	b. Mechanical devices - (1) Foot board.

OBJECTIVE	CONTENT
	(2) Self help devices. (3) Pillows. (4) Hand rolls. (5) Eye glasses. (6) Hearing aid. (7) Dentures. (8) Prosthetic and orthotic devices, use and care of.
State educational and counseling services in restorative care.	c. Educational and counseling services - (1) Prevention of Intellectual regression. (2) Reality Orientation. (3) Remotivation.
Identify the types of ROM exercises.	2. Range of Motion (ROM) - 2 hours 2.1 Range of motion exercises should permit each of the resident's joints to be exercised. There are three types: a. Active exercise is performed by the resident. b. Passive exercises are performed by someone else when a resident cannot carry out such movement. c. Resistive exercises are performed in response to resistance that is offered by a therapist. 2.2 Rules to follow - Range of motion exercises: a. Do each exercise three times. (Follow the head nurse's or team leader's instructions.) b. Follow a logical sequence so that each joint and muscle is exercised. For instance, start at the head and work your way down to the feet. c. If the patient is able to move parts of the body, encourage him to do as much as he can. d. Be gentle. Never bend or extend a body part further than it can go. e. If a patient complains of unusual pain or discomfort in

Unit XI (contd.)

OBJECTIVE	CONTENT
	a particular body part, be sure to report this to your head nurse or team leader.
Identify and demonstrate ROM exercise procedure.	2.3 Procedure - ROM exercises: (refer to procedure #39 in the Appendix) a. Assemble your equipment - (1) Blanket. (2) Extra lighting, if necessary. b. Wash your hands. c. Identify the patient by checking the identification bracelet. d. Ask visitors to step out of the room, if this is your hospital's policy. e. Explain to the patient that you are going to help him exercise his muscles and joints while he is in bed. f. Pull the curtain around the bed for privacy. g. Raise the bed to a comfortable working position. h. Place the patient in a supine position (on his back) with his knees extended and his arms at his side. i. Loosen the top sheets, but don't expose the patient. j. Raise the side rail on the far side of the bed. k. Exercise the neck.
	3. Rehabilitative Care - 2 hours 3.1 Bowel and bladder training:
List goals of bladder and bowel training.	a. Goals of bowel and bladder training - (1) Establish a regular pattern of elimination. (2) Decrease the amount of times a resident is incontinent. (3) Increase a resident's self esteem by attaining control of elimination. (4) Decrease the chance of other problems; e.g.,

OBJECTIVE	CONTENT
	skin breakdown that can occur from continued incontinence. (5) Preserve the integrity and function of the elimination system. b. Preparation for bowel and bladder training - (1) Explain the reason and the importance of possible positive benefits of bowel and bladder training. (2) Encourage involvement of the family members. (3) The resident's past elimination pattern is reviewed, as well as the total resident history. (4) A routine for elimination is established by the nurse and written on the nursing care plan. It is very important that the resident's personal plan of elimination is carried out by the entire staff. (5) Each long term care facility will have a specific program that is followed by the staff. These may be different from facility to facility but the basic goal is the same.
Identify steps in bladder training.	c. Steps involved in bladder training - (1) Provide privacy. (2) Adequate fluid intake. (3) Bedside commode or toilet other than bedpan. (4) Use any technique to stimulate voiding. (5) Adhere to the time schedule as outlined in the care plan of the resident. (6) Regularity is the key to successful program.

OBJECTIVE	CONTENT
	(7) Requires cooperation of shifts. (8) Increase the time interval as possible. (9) Positive reinforcement. (10) Record output and success or non-success each time for evaluation and planning.
Identify steps in bowel training.	d. Steps involved in bowel training - (1) Provide privacy. (2) Encourage resident to eat prescribed diet. (3) Assist resident to bathroom facilities immediately after morning meal. (4) Encourage exercise. (5) Positive encouragement. (6) Encourage fluids. (7) Record success or non-success for evaluation and planning.

APPENDIX

Skills Procedures

Glossary

Common Medical Abbreviations

Maslow's Heirarchy of Needs

References

Curriculum Committee

Acknowledgements

SKILLS PROCEDURES

Difficulty Level I

1. **Assisting the Resident with a Urinal:**
   a. Assemble your equipment: urinal and cover, soap, towels, disposable gloves.
   b. Wash your hands.
   c. Identify the resident and explain what you plan to do.
   d. Provide for privacy.
   e. Ask the resident if he wishes to use the urinal.
   f. Give the resident the urinal. If the resident is unable to put the urinal in place, put his penis into the opening as far as it goes. If the resident is unable to hold it in place, you will have to do so. (Wear gloves for these last two steps.) Raise the head of the bed if the resident prefers.
   g. Ask the resident to signal when he is finished. Leave the room (if appropriate) to give the resident privacy. Wash your hands.
   h. Return when the resident signals.
   i. Put on gloves (if not already done).
   j. Take the urinal. Be careful not to spill it. Cover it and take it to the resident's bathroom (or hopper room).
   k. Check the urine for color, odor, amount.
   l. Measure the urine if necessary or collect specimen if necessary.
   m. Rinse the urinal with cold water. Clean it per facility policy and return it to its proper place.
   n. Remove and dispose of gloves.
   o. Wash your hands.
   p. Return to the resident. Help him wash his hands in a basin of water or wet wash cloth.
   q. Make the resident comfortable. Place call bell within reach.
   r. Make a notation on the resident's chart that he has used the urinal. Also note anything you have observed about the resident during this procedure.

2. **Measuring and Recording of Fluid Intake:**
   a. Assemble your equipment: I&O record at bedside, pen, graduated pitcher.
   b. Wash your hands.
   c. Identify the resident and explain what you plan to do
   d. Ask the resident to help by recording the amount of fluid taken by mouth (if appropriate).
   e. Record intake on the I&O record at bedside. Intake includes:
      -amount of liquid resident takes with meals (this includes anything liquid at room temperature such as ice cream or jello.
      -amount of water and other liquids taken between meals.
      -all other intake including fluids given by mouth, intra-

venously, or by tube feeding. How it is taken should also be recorded.

f. Record intake after each meal before the tray is removed.
g. Record other intake as it is consumed.
h. Convert amounts to cubic centimeters (cc).
i. Record information on resident's chart per facility policy.

3. **Measuring and Recording of Urinary Output:**

a. Assemble your equipment: bedpan, cover and urinal or container for urine, measuring container, pad and pencil, gloves.
b. Wash your hands and put on gloves.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Pour the urine from the bedpan or urinal into the measuring container.
f. Place the measuring container on a flat surface for accuracy in measurement.
g. At eye level, carefully look at the container to see the number reached by the level of urine - remember it.
h. Rinse and return the measuring cup to its proper place. Pour the urine and rinse water into the toilet.
i. Rinse and return the urinal or bedpan to its proper place. Pour the rinse water into the toilet.
j. Remove and dispose of gloves.
k. Wash your hands.
l. Record the amount of urine in "cc" and the character of the urine on the output side of the I&O sheet.

4. **Measuring Height and Weight:**

a. Assemble your equipment: scale with height rod, pad, pencil.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Encourage resident to urinate before measuring weight.
f. Cover the platform scale with a paper towel.
g. Raise the height measurement rod.
h. Assist the resident to remove slippers and robe if appropriate.
i. Slide the balance printer on the scale until it balances on the dial.
j. Accurately record the resident's name and weight on the pad.
k. Assist the resident to stand as straight as possible being sensitive to his/her safety.
l. Lower the rod that measures height
m. Assist the resident to safely step off the scales or move away from the weighing device.
n. Accurately record the resident's height on the pad.
o. Assist the resident to put on robe and slippers if appropriate.

p. Assist the resident back to his/her room. Make resident comfortable. Place call bell within reach.
q. Return scales and equipment to proper storage area.
r. Wash hands.

5. **Taking Axillary Temperature:**
a. Assemble your equipment: oral thermometer, tissue or paper towel, pad and pencil, watch.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Remove the thermometer from its case and shake down the mercury so that it is below the numbers and lines.
f. Inspect the thermometer for cracks and chips. Do not use if you see any flaws.
g. Remove the resident's arm from the sleeve. If the axillary region is moist with perspiration, pat it dry with a towel.
h. Place the bulb of the oral thermometer in the center of the armpit in an upright position.
i. Put the resident's arm across his/her chest or abdomen.
. If the resident is unconscious or to weak to help, you will have to hold the arm in place.
j. Leave the thermometer in place 10 minutes. Stay with the resident.
k. Remove the thermometer. Read the thermometer and record temperature.
l. Clean the thermometer according to facility policy and procedure and return it to the container.
m. Make resident comfortable. Place call bell within reach.
n. Wash your hands.

6. **Taking Radial Pulse:**
a. Assemble your equipment: watch with a second hand, pad and pencil.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Have the resident in a sitting or lying position.
e. The resident's hand and arm should be well supported and resting comfortably.
f. Find the pulse by putting the first three fingers of your right hand on the radial artery and press very gently against the artery until the pulse is felt (never use your thumb to take the pulse because it has a pulse beat and you would be counting your own pulse).
g. While looking at the second hand of your watch, keep your fingers gently on the pulse and count the number of beats per minute.
h. Record the pulse rate, rhythm and force immediately.
i. Make the resident comfortable. Place call bell within reach.
j. Wash your hands.

SKILLS PROCEDURES

7. **Taking Respiration:**
   - a. Assemble your equipment: watch with a second hand, pad and pencil.
   - b. Wash your hands.
   - c. Identify the resident and explain what you plan to do.
   - d. Place the resident's arm across his/her chest while holding the wrist. You can feel their breathing.
   - e. Look at the second hand on your watch.
   - f. As the resident's chest rises (when they breath in) count one.
   - g. Count the next time the chest rises.
   - h. Continue to do this for one full minute.
   - i. While counting the respirations, observe the characteristics of the resident's breathing.
   - j. Record your findings immediately.
   - k. Make the resident comfortable. Place call bell within reach.
   - l. Wash your hands.

8. **Meal Service - Serving a Tray:**
   - a. Wash your hands.
   - b. Obtain food tray and check for diet card. Diet card must accompany the tray to the resident.
   - c. Check the diet card to ensure the right food for the right resident.
   - d. Observe the food content of the tray. Is the food correct? Presentable?
   - e. Check the tray for necessary items: self help devices, napkin, condiments, fluids.
   - f. Adjust the tray for comfort to the resident (height and availability).
   - g. Assist in the preparation of the food as needed.
   - h. Encourage and assist the resident as needed. Always encourage independence.
   - i. Remove the tray when resident has finished.
   - j. Note and record the food eaten or not eaten. Record fluids on intake record, if required.
   - k. Wash your hands.

9. **Handwashing:**
   - a. Assemble your equipment: soap, paper towels, waste can.
   - b. Turn on the faucet with a paper towel held between the hand and the faucet. Drop the paper towel into the waste can.
   - c. Wet hands with fingertips pointed downward.
   - d. Apply skin cleanser or soap to hands.
   - e. Hold your hands downward and lower than your elbows while washing.
   - f. Rub hands together vigorously for at least 10 seconds.
   - g. Work up a good lather. Spread it over the entire area of your hands and wrist (two inches above the wrist). Get soap under your nails and between your fingers. Add water while washing.

h. Rinse thoroughly from wrist to fingertips, keeping fingertips down.
i. Dry hands thoroughly with a paper towel.
j. Use a paper towel to turn off the faucet.
k. Discard the paper towel into the waste can.
l. Do not touch the waste can.
m. Do not touch the inside of the sink with clean hands.
n. Do not lean against the sink or splatter uniform.

Difficulty Level II

10. **Application of Protective Restraints:**
    a. Check to be sure the application of the restraint has been ordered by a physician.
    b. Assemble the equipment.
    c. Identify the resident and explain what you plan to do. Display a positive, gentle attitude. Use terms that stress the protective nature of the restraint, such as "safety belt", and "postural support".
    d. Restrain the resident only in beds or chairs with wheels.
    e. Tie the restraint under the chair out of reach of the resident or to the bed frame. Never tie the restraint to side rails or part of the bed that would cause tightening when the positioning of the bed is changed. Do not use a slip knot to secure ties.
    f. Check the resident for proper positioning (properly aligned and comfortable).
    g. Make sure the restraint is not too tight. The resident should have some movement allowed with the restraint on.
    h. Make sure the resident is protected from pressure caused by knots, wrinkles or buckles. Pad areas under restraint to prevent friction.
    i. Make sure that water and call bell are within reach.
    j. If possible, place the restrained resident in an area where they can be closely observed.
    k. Check the resident frequently. Check every thirty (30) minutes making sure to check for restricted circulation. Release every two (2) hours for at least ten (10) minutes for exercise, range of motion and to use the bathroom.
    l. Report and chart per facility policy.

11. **Collecting a Routine Fecal (Stool) Specimen:**
    a. Assemble your equipment: bedpan and cover, stool container, label, wooden tongue depressor, tissue, washcloth and towel for resident, disposable gloves.
    b. Make out label including: resident's full name, room number, date and time of specimen (fill in time when actual specimen has been collected), and other information as requested. Put label on container.

c. Wash your hands.
d. Identify the resident and explain what you plan to do. Ask the resident to call you when he/she feels the need to move the bowels.
e. Provide for privacy.
f. Put on gloves.
g. Follow the procedure for giving and receiving the bedpan. If the resident is unable to use the bedpan, place several layers of toilet tissue in the bottom of the toilet and have the resident move their bowels on the paper.
h. Ask the resident not to urinate into the bedpan and not to put toilet tissue into the bedpan. Provide a plastic or paper bag to temporarily dispose of the tissue and discard in the toilet.
i. After the resident has had a bowel movement, take the bedpan into the bathroom (or hopper room).
j. Using the wooden tongue depressor, take 1-2 tablespoons of stool from the bedpan and place it into the stool specimen container.
k. Cover the container. Do not touch the inside or top of the container.
l. Wrap the depressor in a piece of toilet tissue and discard it into a plastic or paper bag.
m. Empty the remaining feces (stool) into the toilet.
n. Clean the bedpan and return it to its proper place.
o. Remove and dispose of gloves.
p. Wash your hands.
q. Offer the resident a washcloth and towel for his/her hands. Assist as necessary. Make the resident comfortable. Place call bell within reach.
r. Make a notation on the resident's chart that you have collected the specimen, the time and anything that you observed during the procedure.
s. Store the specimen in the correct place until it is taken to the laboratory.

12. **Collecting a Routine Urine Specimen:**
a. Assemble your equipment: bedpan or urinal, measuring container, urine specimen container and lid, paper or plastic bag, tissue, label, wet washcloth and towel, disposable gloves.
b. Make out label including: resident's full name, room number, type of specimen, date and time, and other information as requested. Put label on container.
c. Wash your hands.
d. Put on gloves.
e. Identify the resident and explain what you plan to do.
f. Provide for privacy.
g. Explain the procedure. Some residents may be able to collect the specimen themselves and should be allowed to do so. If the resident is able, he can urinate directly into the con-

tainer. If not, ask the resident to urinate into the clean bedpan or urinal. Remind the resident not to put toilet tissue into the bedpan or urinal and to use the paper bag provided. You will discard the tissue into the toilet.

h. Take the bedpan or urinal into the bathroom (or hopper room).
i. If the resident is on I&O, pour the urine into a clean measuring container and note the amount of urine on the I&O chart.
j. Pour the urine into the specimen container, fill it 3/4 full.
k. Put the lid on the container, wipe off the outside of the container.
l. Pour the urine remaining in the bedpan, urinal or measuring container into the toilet.
m. Clean and rinse the bedpan, urinal and measuring container. Put them in their proper place.
n. Remove and dispose of gloves.
o. Wash your hands.
p. Offer the resident a washcloth and towel to wash his/her hands. Assist as necessary. Make the resident comfortable. Place call bell within reach.
q. Make a notation on the resident's chart that you collected the specimen, the time and anything you observed about the resident during this procedure.
r. Store the specimen in the correct place until it is taken to the laboratory.

13. **Use of Wheelchair/Geriatric Chair:**

a. The resident shall be covered to protect from chilling. Blankets shall be kept away from the wheels. Tuck the blanket firmly around the resident.
b. The wheelchair or gerichair shall be wiped off with a disinfectant after each use, if it is to be used by others.
c. Push the wheelchair or gerichair from behind except when going in and out of elevators. Pull the wheelchair or gerichair into and out of the elevator
d. If moving a resident down a ramp, take the wheelchair or gerichair down backwards. Glance over your shoulder to be sure of your direction and to prevent collisions and falls.
e. Set the brakes when: assisting a resident into a wheelchair or gerichair, assisting a resident out of a wheelchair or gerichair, when the wheelchair or gerichair is to remain stationary.
f. Put foot rests up when assisting resident in and out of wheelchairs or gerichairs.
g. Have the resident's feet on the foot rests when moving to prevent injury. Never push the wheelchair if the foot rests are in an up position.
h. If safety straps are needed, they shall be fastened correctly. Observe the resident's feet, elbows and hands when turning or going down corridors.
i. Pay attention where you are going and push chair slowly.
j. Slow down at corners and look before moving the wheelchair or

gerichair to prevent collisions with other residents, staff, etc.

14. **Moving a Resident in Bed from Side to Side:**
    a. Wash your hands.
    b. Identify the resident and explain what you plan to do.
    c. Provide for privacy.
    d. Lock the wheels of the bed.
    e. Raise the whole bed to the highest position best for you.
    f. Lower the backrest and footrest, if this is allowed.
    g. Put the side rail in the up position on the far side of the bed.
    h. Loosen the top sheets but do not expose the resident.
    i. Place your feet in a good position - one in close to the bed - one back. Slide both of your arms under the resident's back to his far shoulder, then slide the resident's shoulders toward you by rocking your weight to your back foot.
    j. Keep your knees bent and your back straight as you slide the resident.
    k. Slide both your arms as far as you can under the resident's buttocks and slide his/her buttocks toward you in the same way. Use a pull (turning) sheet whenever possible for helpless residents.
    l. Place both your arms under the resident's feet and slide them toward you.
    m. Replace and adjust the pillow, if necessary.
    n. Remake the top of the bed.
    o. Make the resident comfortable. Lower the bed to its lowest horizontal position. Place call bell within reach.
    p. Record/report completion of procedure and note any observations made about the resident.

15. **Oral Hygiene for the Conscious Resident:**
    a. Assemble your equipment: soft bristle toothbrush, toothpaste, paper cup filled with cool water, mouthwash (if desired), dental floss, emesis basin and towel (if resident is unable to go to the bathroom or sink), disposable gloves.
    b. Wash your hands.
    c. Put on gloves.
    d. Identify the resident and explain what you plan to do.
    e. Provide for privacy.
    f. Encourage the resident to do as much of his/her own care as possible.
    g. Position the resident sitting upright in a chair or in bed. Drape a towel under the chin and chest.
    h. Moisten the toothbrush and apply toothpaste.
    i. Clean upper teeth and gums.
    j. Clean lower teeth and gums.
    k. Gently massage the gums by pointing the bristles toward the gums. Alternate brushing side to side and downward motion for upper teeth and upward motion for lower teeth.

l. Offer water for the resident to rinse as is necessary.
m. Provide the emesis basin for the resident to empty his/her mouth as is necessary.
n. Finish by having the resident rinse the mouth thoroughly with plain water (and mouthwash if desired).
o. Clean and replace equipment in the resident's bedside table.
p. Remove and dispose of gloves.
q. Wash your hands.
r. Make resident comfortable. Place call bell within reach.
s. Record that the procedure was completed and note any observations made about the resident.

16. **Oral Hygiene for the Resident with Dentures:**
a. Assemble your equipment: water, labeled cup, toothbrush, toothpaste, emesis basin or sink, face towel, disposable gloves.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Place paper towel in sink to protect dentures.
f. Put on gloves.
g. Rinse dentures under cool water.
h. Fill cup with soaking solution, place dentures in cup.
i. Help resident to rinse and clean mouth.
j. Help resident to replace dentures.
k. Leave labeled cup close at hand for resident.
l. Clean your equipment and replace in proper place.
m. Remove and dispose of gloves.
n. Wash your hands.
o. Make resident comfortable. Place call bell within reach.
p. Make a notation that the procedure was completed and note any observations made about the resident.

17. **Taking Oral Temperature:**
a. Assemble your equipment: clean oral thermometer in case, tissue or paper towel, pad and pencil, watch.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Ask the resident if he/she has recently had hot or cold liquids, or if recently smoked. If yes, wait 10 minutes before taking temperature.
e. The resident should be in bed or sitting in a chair. Do not take a temperature while the resident is walking.
f. Take the thermometer out of the container and inspect it for cracks and chips. Do not use if defective.
g. Shake the mercury down until it is below the calibrations.
h. Run the thermometer under cool water. This will make the thermometer more pleasant in the resident's mouth.
i. Ask the resident to lift up their tongue. Place the bulb end of the thermometer under the tongue. Ask the resident to keep their lips gently around the thermometer without biting it.

j. Leave the thermometer in place for at least three (3) minutes. For the most accurate reading, leave the thermometer in place for eight (8) minutes.
k. Stay with the resident.
l. Take the thermometer out of the resident's mouth. Hold the stem end and wipe the thermometer with a tissue from the stem towards the bulb.
m. Read the thermometer.
n. Record the temperature and any observations made about the resident during the procedure.
o. Shake down the mercury.
p. Clean the thermometer. Replace the thermometer in its container. Store according to facility policy and procedure.
q. Wash your hands.
r. Make resident comfortable. Place call bell within reach.

18. **Shaving a Resident:**
a. Assemble your equipment: bedside table, basin of very warm water, shaving cream, safety razor, face towel, mirror, tissues, aftershave lotion (optional), face powder (optional), washcloth, disposable gloves..
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Adjust a light so that it shines on the resident's face but not in his eyes.
f. Raise the bed to a proper height. Raise the head of the bed if possible.
g. Spread the towel under the resident's chin. If the resident has dentures, make sure they are in his mouth.
h. Put on gloves.
i. Apply shave cream to face.
j. Hold skin tight as you shave in the direction the hair grows. Use short firm strokes. Start under the sideburns and work downward over the cheeks. Continue carefully over the chin. Work upward on the neck under the chin.
k. Rinse razor often in water.
l. If you nick the resident's skin, report this to your supervisor.
m. Wash off remaining shaving cream when you have finished.
n. Apply aftershave or powder (optional).
o. Clean equipment and return it to its proper place.
p. Remove and dispose of gloves.
q. Wash your hands.
r. Lower the bed to lowest position. Make the resident comfortable. Place call bell within reach.
s. Record that the procedure was completed and note any observations made about the resident.

19. **Fingernail Care:**
a. Assemble your equipment: washbasin 3/4 full with warm soapy

water, hand or bath towel, paper towel, orangesticks, clippers, nail file or emery board, lotion.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Assist the resident to a comfortable position in bed or chair and adjust overbed table in front.
f. Soak the fingers in the basin of warm soapy water for at least five (5) minutes.
g. Either soak both hands together or one at a time. Encourage the resident to exercise fingers while soaking.
h. Rinse the hands with warm clean water and dry with hand or bath towel.
i. If soaking one hand at a time, have the resident start soaking the second hand.
j. Gently remove dirt from around and under each fingernail with an orangestick, cleaning dirt from the orangestick on the paper towel.
k. Trim nails in an oval shape, taking care not to trim below the skin line or cut the skin. Report any cuts to supervisor.
l. Smooth the nails with an emery board or file.
m. Repeat the same procedure for the second hand.
n. Apply lotion (optional).
o. Clean equipment and return to its proper place.
p. Wash your hands.
q. Make resident comfortable. Place call bell within reach.
r. Record/report completion of procedure and note any observations made about the resident.

Difficulty Level III

20. Foot and Toenail Care:

a. Assemble your equipment: washbasin 3/4 full with warm soapy water, bath towel and washcloth, paper towel, orangesticks, clippers, bath mat, lotion.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. If permitted, assist resident out of bed and into chair.
f. Place bath mat on floor in front of resident. Put water basin on mat.
g. Remove slippers and assist resident to put feet in water. Cover with bath towel to help retain heat.
h. Soak feet for at least five (5) minutes.
i. At the end of the soak period, wash feet with washcloth scrubbing roughened areas. Rinse and dry feet and toes thoroughly.
j. Clean around and under the toenails with an orangestick following the same procedure used for cleaning the fingernails.
k. Check with the charge nurse before trimming the resident's

toenails. Residents with poor circulation to the feet or diseases such as diabetes will usually have their toenails trimmed by a podiatrist. For residents without these problems, you will need to trim the toenails regularly, using the same equipment as with the fingernails.

l. If trimming is allowed, trim the toenails straight across to prevent the edges from becoming ingrown.
m. Inspect the feet and in between each toe for condition of skin, presence of corns, callouses or other foot problems and circulation. Apply lotion.
n. Assist resident with putting on clean stockings, socks, shoes or slippers.
o. Clean equipment and return to its proper place.
p. Wash your hands.
q. Return resident to bed (if needed) and make comfortable. Place call bell within reach.
r. Record/report completion of procedure and note any observations made about the resident.

21. **Hair Care - Shampoo in Bed:**

a. Assemble your equipment: comb and brush, shampoo, conditioner (optional), containers of warm to hot water, chair, pitcher, large basin or pail to collect dirty water, bed protectors, several large bath towels, washcloth, water trough or 1 & 1/2 yards of 60" wide plastic, cotton balls (optional), bath blankets, water proof pillow (optional), electric blow dryer (optional), curlers (optional).
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Raise the bed to the highest horizontal position. Lower the headrest and the side rails on the side you are working.
f. Place a chair at the side of the bed near the resident's head. The chair should be lower than the mattress. The back of the chair should be touching the mattress.
g. Place a towel on the chair. Place the large basin or pail on the towel.
h. Replace pillow case with waterproof covering (optional).
i. Replace top bedding with bath blanket. Fanfold the top sheets to the foot of the bed without exposing the resident.
j. Ask resident to move across the bed so that his/her head is close to where you are standing. Position pillow under shoulders so that head is tilted slighted backward.
k. Place the bed protectors on the mattress under the resident's head.
l. Loosen the pajamas so the resident is comfortable and clothing is not in the trough. Put small amount of cotton in the resident's ears, if needed.
m. Place towel under the resident's head and shoulders. Give resident a washcloth to cover eyes.
n. Inspect the resident's hair for knots or lice. If the resi-

dent has knots, carefully comb them out. If the resident has lice, stop the procedure and report this to your supervisor.

o. Pour some water over the resident's hair using a pitcher or cup. Adjust the water temperature to resident's preference. Repeat until the hair is completely wet.
p. Apply shampoo and using both hands, wash the hair and massage the scalp with your fingertips. Rinse the shampoo off by pouring water over the hair. Have the resident turn from side to side. Repeat until hair is free from soap.
q. Dry the resident's forehead and wrap head in a bath towel.
r. Rub the resident's hair with a towel to dry it as much as possible. If available and not counterindicated, a portable hair dryer may be used to complete the drying process.
s. Comb and prepare hair per the resident's preference.
t. Replace bedding and remove the bath blanket. Bring up the top sheets to cover the resident.
u. Lower the bed to its lowest position and raise the side rails.
v. Clean your equipment and return to its proper place.
w. Wash your hands.
x. Make the resident comfortable. Place call bell within reach.
y. Record/report completion of the procedure and note any observations made about the resident.

22. **Hair Care - Combing the Resident's Hair:**

a. Assemble your equipment: towel, paper bag, comb or brush, any hair preparation the resident normally uses, hand mirror.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. If possible, comb the resident's hair after the bath (and/or shampoo) and before you make the bed.
f. If the resident wears glasses, ask him/her to remove them.
g. Part the hair down the middle to make it easier to comb.
h. Brush the resident's hair carefully, gently and thoroughly. Be sure to brush the back of the head.
i. Ask the resident to turn his/her head from side to side or turn it for them so you can reach the entire head.
j. For the resident who can not sit up, separate the hair into small sections. Then comb/brush each section separately, using a downward motion, starting at the loose ends and working up towards the head.
k. Complete brushing/combing and arrange attractively per resident's preference. Let the resident use the mirror.
l. If the resident has long hair, suggest braiding it to keep it from getting tangled.
m. Clean equipment and return to its proper place.
n. Wash your hands.
o. Make the resident comfortable. Place call bell within reach.
p. Record/report completion of the procedure and note any observations made about the resident.

23. Assisting the Resident with a Bedpan:

a. Assemble your equipment: bedpan and cover or fracture bedpan and cover, toilet tissue, wash basin with water or wet wash cloth, soap, talcum powder or corn starch, hand towel, gloves.
b. Wash your hands.
c. Identify the resident and explain what you plan to do. Ask the resident if he/she would like to use the bedpan.
d. Provide for privacy.
e. Put on gloves (optional).
f. Raise the bed to highest horizontal position. Lower the side rails on the side where you are standing.
g. Fold back top sheets so they are out of the way.
h. Raise the resident's gown, but keep the lower part of the body covered with the top sheets.
i. Ask the resident to bend his/her knees and put their feet flat on the mattress. Then the resident to raise their hips. If necessary, help the resident to raise their buttocks by slipping your hand under the lower part of the back.
j. Place the bedpan in position with the seat of the bedpan under the buttocks.
k. If the resident is unable to lift his/her buttocks to get on or off the bedpan, then turn the resident on their side with their back to you. Put the bedpan against the buttocks. Then turn the resident back onto the bedpan.
l. Replace the covers over the resident. Raise the backrest and knee rest, if allowed, so the resident is in a sitting position.
m. Raise the side rails to the up position.
n. Put toilet tissue where the resident can reach it easily.
o. Remove gloves (if used) and wash your hands.
p. Ask the resident to signal when finished.
q. Leave the room to provide for privacy (unless counterindicated). Make sure the signal cord is within easy reach. When the resident signals, return to the room and put on gloves.
r. Lower side rails. Help the resident to raise his/her hips so you can remove the bedpan.
s. Help the resident if he/she is unable to clean themselves. Turn the resident on their side and clean the anal area with tissue. Discard tissue in bedpan unless specimen is to be collected. Cleanse resident with warm water and soap.
t. Raise the side rails. Cover bedpan immediately. You can use a disposable pad or paper towel if no cover is available.
u. Take the bedpan to resident's bathroom (or hopper room).
v. Return to the resident. Offer the resident the opportunity to wash their hands and freshen up. Change linens or protective pads as necessary.
w. Note the excreta (feces or urine) for amount, odor, color. If a specimen is required, collect it at this time. Measure the urine if necessary.
x. Empty the bedpan into the toilet. Clean the bedpan and other equipment and return to its proper place. Cold water is

always used to clean the bedpan.
- y. Remove and dispose of gloves. Wash your hands.
- z. Make resident comfortable. Place call bell within reach.
- aa. Record/report completion of the procedure and note any observations made about the resident.

24. **Giving a Back Rub:**
- a. Assemble your equipment: bath towel, lotion, basin of water warmed to 105 F.
- b. Wash your hands.
- c. Identify the resident and explain what you plan to do.
- d. Provide for privacy.
- e. Raise the bed to the highest position. Keep the side rails up on the far side of the bed.
- f. Place lotion in basin of water to warm.
- g. Ask the resident to turn on his/her side or abdomen. Position the resident as close to the side of the bed where you are working as possible.
- h. Expose the resident's back.
- i. Pour a small amount of lotion in the palm of your hand. If lotion is not warm enough, rub hands together to warm.
- j. Apply the lotion to the back using long firm strokes (advise the resident it may feel cool). Continue strokes from the buttocks to the back of the neck and shoulders.
- k. Exert firm upward pressure. Use gentle downward pressure rubbing in small circular motion with palm of hands. Do not lift hands.
- l. Give special attention to all bony prominences using circular motion.
- m. Continue rhythmic rubbing for one (1) to three (3) minutes.
- n. Dry resident's back by patting with a towel.
- o. Assist resident with putting on gown or pajamas.
- p. Clean equipment and return to its proper place.
- q. Wash your hands.
- r. Make resident comfortable. Place call bell within reach.
- s. Record/report completion of procedure and note any observations made about the resident.

25. **Dressing and Undressing a Resident:**
- a. Wash your hands.
- b. Identify the resident and explain what you plan to do.
- c. Provide for privacy.
- d. Select appropriate clothing and arrange in order of application. Encourage resident to participate in selection.
- e. Raise bed to comfortable working position.
- f. Assist resident to comfortable sitting position on the edge of bed or lie flat.
- g. Remove night clothing, keeping resident covered with bath blanket.
- h. To put on a shirt remember to place injured, inflexible or compromised limb in the garment first. Grasp resident's

hand and guide it through the arm hole by reaching into the arm hole from the outside. Repeat procedure with opposite arm.

i. Assist with underwear, trousers or pajamas. If the resident is lying down, they may lift up buttocks while you pull up clothing.
j. Never jerk, pull or yank on a limb.
k. Place socks or stockings on feet. Never use round garters since they reduce circulation. When placing feet in socks and shoes, remember to check for blisters or red areas
l. Wash your hands.
m. Make resident comfortable. Place call bell within reach.
n. Record/report completion of the procedure and note any observations made about the resident.

26. **Heimlich Maneuver:**

a. Ask the resident, "Can you speak?". If the resident can speak, cough or breathe, do not interfere. If the material does not dislodge, apply the Heimlich Maneuver.
b. Call for "HELP".
c. Stand behind the resident and wrap your arms around them.
d. Put the thumb side of one hand on the abdomen (thumb should be tucked into fist). Place fist, thumb side in, against abdomen between naval and tip of sternum.
e. Grasp this hand with the other hand while bending resident forward slightly and press it into the abdomen with a quick upward movement.
f Repeat until the foreign object is expelled (6 to 10 times) or until the resident becomes unconscious.
g. Again call for "HELP". Licensed, trained personnel should be summoned to activate CPR and/or calling 911.

27. **Making an Unoccupied Bed:**

a. Assemble your equipment: two large sheets (substitute one fitted sheet, if used), pillow cases, bedspread, clean blankets, draw sheet (if used at your facility), mattress pad and cover.
b. Wash your hands.
c. Lock bed wheels so the bed will not roll and place chair at the side of the bed. Arrange linen on chair in order in which it is to be used. Adjust bed to a comfortable working height.
d. Remove soiled linen holding it away from your uniform and discard immediately into laundry bag.
e. Position mattress to head of bed by grasping handles on side.
f. Place mattress cover on mattress and adjust it smoothly. If mattress cover is not used, check the mattress for any soiling or wetness. Wipe mattress with slightly dampened cloth and allow to dry.
g. Unfold each piece of clean linen centered on the bed beginning with the bottom sheet. Hem seams face the mattress.
h. Hem is even with the foot of the mattress and the fold is in

the exact center of the bed from head to foot. Open the sheet from the fold until the sheet covers the entire mattress evenly. Tuck the sheet under the mattress lightly.

i. Work entirely on one side of the bed until that side is finished.
j. Place the draw sheet (if used) about 14 inches down from the head of the bed. Tuck it in.
k. Place the top sheet so that the fold is in the center. The wide hem is at the top with the seam on the outside.
l. Place the spread on top of the sheet.
m. Tuck in the spread at the foot of the bed with a square corner at the bottom end.
n. Smooth the sheet and spread from the bottom to the top and fold down the top hem of the sheet over the top of the spread.
o. Go to the opposite side of the bed and proceed to make that side of the bed in the same manner. Pull sheets tight.
p. Put the pillow cases on the pillows holding the pillow away from your body and uniform. Place pillow at head of bed with open end away from the door.
q. Place chair and bedside table at assigned location.
r. Wash your hands.
s. Record/report completion of the procedure.

28. **Taking Rectal Temperature:**

a. Assemble your equipment: rectal thermometer in a case, tissue or paper towel, lubricating jelly, pad and pencil, watch, disposable gloves.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Place the bed in a flat position, if possible.
f. Put on gloves.
g. Take thermometer out of its container. Hold the stem.
h. Inspect for any cracks or chips. Do not use if you see any defects.
i. Shake down the mercury until it is below the calibrations.
j. Put a small amount of lubricating jelly on a piece of tissue. Lubricate the bulb of the thermometer with the jelly.
k. Ask the resident to turn on his/her side. Assist as necessary. Turn back top covers just enough that you can see the resident's buttocks. Avoid overexposing the resident.
l. With one hand, raise the upper buttock until you see the anus. With the other hand, gently insert the bulb one inch through the anus into the rectum.
m. Hold the thermometer in place for three (3) minutes.
n. Remove the thermometer from the resident's rectum. Hold the stem end of the thermometer and wipe it with a tissue from stem to bulb to remove particles of feces.
o. Read the thermometer.
p. Remove your gloves.
q. Record the temperature. Note that this is a rectal tempera-

ture by writing an "R" after the figure. Report any abnormal readings immediately to your charge nurse. Note any other observations made about the resident.

r. Clean and store thermometer in its proper place.
s. Wash your hands.
t. Make resident comfortable. Place call bell within reach.

29. **Taking Blood Pressures:**

a. Assemble your equipment: sphygmomanometer, stethoscope, antiseptic pad to clean earpiece of stethoscope, pad and pencil.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Wipe the earplugs of stethoscope with the antiseptic pad.
f. Have the resident resting quietly. He/she should be either lying down or sitting in a chair.
g. If you are using mercury scale apparatus, the measuring scale should be level with your eyes.
h. The resident's arm should be bare up to the shoulder, or the resident's sleeve should be well above the elbow (but not tight).
i. The resident's arm from the elbow down should be fully extended on the bed. Or, it might be resting on the arm of the chair or your hip, well supported, with the palm upward.
j. Unroll the cuff and loosen the valve on the bulb. Then squeeze the compression bag to deflate it completely.
k. Wrap the cuff around the resident's arm above the elbow snugly and smoothly. Do not wrap it so tightly that the resident is uncomfortable from the pressure
l. Leave the area clear where you place the bell or diaphragm of the stethoscope.
m. With your fingertips, find the resident's brachial pulse. Hold your fingers there and inflate the cuff until the pulse disappears.
n. When the pulse disappears, pump the cuff up another 30 points. At this point tell the resident they may feel a numb, tingling sensation in his/her arm.
o. Gently but quickly place the bell of the stethoscope over the brachial pulse, holding it firmly in place with three fingers.
p. Open the valve carefully and slowly allow the cuff to deflate.
q. Listen intently while observing the sphygmomanometer scale.
r. Continue to loosen the control valve slowly and observe the pressure dropping as you listen for the systolic beat (first beat). The first clear definite beat, though faint, will be the systolic pressure of the heart. Remember the number.
s. As you continue to deflate the cuff slowly, the mercury column or pointer will drop evenly and the beats will become soft and muffled.
t. The last definite beat that you hear is the diastolic pressure of the heart. Remember the number.
u. At this point deflate the cuff quickly until all the air is

out.

v. Record your findings by writing the systolic pressure over the diastolic pressure, for example 120/80.
w. Remove the cuff.
x. Clean the earpiece of the stethoscope and store it according to facility policy.
y. Wash your hands.
z. Make the resident comfortable. Place call bell within reach.

30. **Transfer/Discharge of the Resident:**

a. Before transferring a resident to another unit, be sure that the receiving unit has been properly prepared.
b. Inform the resident of the move, answering questions as your instructions permit.
c. Collect all personal items that are to be moved with the resident.
d. Depending on whether the resident is to be moved in his/her own bed, a wheelchair or a stretcher, use procedures learned on moving and transporting.
e. You may be expected to go with the resident to provide for their physical and emotional comfort. The resident may need reassurance and some assistance in getting acquainted in their new unit.
f. Before discharging a resident, gather the resident's personal possessions. Secure valuables per facility policy.
g. Offer to help the resident pack. Help the resident dress, if necessary.
h. Before the resident leaves the unit, ask the charge nurse to confirm that all discharge procedures have been completed. When the resident leaves, the nursing assistant should direct their efforts to making this a pleasant experience, leaving the resident with a happy memory.
i. Record/chart per facility procedure.

Difficulty Level IV

31. **Checking for a Fecal Impaction:**

Note: Check the facility policy to make sure this procedure is allowed to be performed by a nursing assistant.

a. Assemble your equipment: washcloth and towel, basin of warm water, toilet tissue, bath blanket, protective pad, lubricant, disposable gloves.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Raise bed to a comfortable position. Lower side rails on side closest to you.
f. Ask resident to raise hips. Place bed protector under hips.
g. Turn resident to lay on side (assist as necessary) facing away

from you.
h. Cover with bed blanket and fanfold top bedclothes to foot of the bed.
i. Put on gloves. Lubricate index finger of dominant hand.
j. Ask resident to take a deep breath and bear down as you insert lubricated finger into the rectum. Note: Rectum should feel soft and pliable. You may feel no feces or you may feel a soft stool, a large solid mass, or multiple hard formations.
k. Withdraw finger. Note: If a spontaneous bowel movement occurs, note amount and character.
l. Remove gloves, wash hands and put on clean gloves.
m. Wash the resident's buttocks with warm water and dry.
n. Assist resident onto back. Ask resident to raise hips and withdraw bed protector.
o. Remove protector and gloves, folding down from outside to inside-out, and place on chair.
p. Pull bedding up and remove bath blanket. Raise side rails.
q. Clean equipment and return to its proper place. Dispose of protector and gloves according to facility policy.
r. Wash your hands.
s. Make resident comfortable. Leave call bell within reach.
t. Record/report completion of procedure and findings to charge nurse. Note any observations made about the resident.

32. **Administering a Pre-packaged (Saline Solution) Enema:**
Note: Check the facility policy to make sure this procedure is allowed to be performed by a nursing assistant. Enemas should be given only at the charge nurse's instruction and direction.
a. Assemble your equipment: pre-packaged enema, bedpan and cover, towels, soap, basin of water, toilet tissue, bath blanket, bed protector, disposable gloves.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Fanfold the covers to the foot of the bed as you cover the resident with a bath blanket.
f. Place chair at foot of bed, cover with a towel and place bedpan on chair.
g. Place bed protector under buttocks.
h. Have the resident turn on his/her left side, if possible (assist as necessary). Have resident's hips near the edge of the bed on the side where you will be working.
i. Turn back the bath blanket (or sheet) so that the resident's hips are exposed while the rest of his/her body is covered. Expose the resident's anus.
j. Put on gloves.
k. Follow instructions on the pre-packaged solution. Instruct resident to take a deep breath while you insert pre-lubricated tip into the anus. Squeeze container until all the solution has entered the rectum.
l. When the solution has been inserted, remove the tip and dis-

pose of the container.

m. Encourage the resident to remain on side. Tell the resident to try to hold the solution for 20 minutes. Provide privacy if the resident is able to be left alone. Place call bell and toilet tissue within reach. Remove gloves and wash hands.

n. Check resident every 5 minutes until solution has been retained for 20 minutes.

o. Position resident on bedpan or assist to bathroom. If resident is on bedpan, raise head of bed to comfortable position. Place toilet tissue and call bell within easy reach. If resident is in the bathroom, stay nearby.

p. Report immediately if the resident has had difficulty expelling the solution.

q. Put on gloves and remove bedpan or assist resident to return to bed. Observe and note contents of bedpan or toilet. Cover pan and dispose of in flush toilet.

r. After you are finished, remove and dispose of all articles properly according to facility policy. Clean bedpan and return to its proper place. Remove and dispose of gloves.

s. Wash your hands.

t. Assist resident to wash his/her hands.

u. Remove the bath blanket. Straighten the bed covers.

v. Make resident comfortable. Place call bell within reach.

w. Record/report completion of procedure and note any observations made about the resident.

33. **Admission of a Resident:**

a. Assemble your equipment: pad and pencil, stethoscope, blood pressure cuff, thermometer, scales, watch with second hand, inventory record, resident's record, other equipment/supplies needed for admission.

b. Prepare the unit for the resident by making sure that all necessary equipment and furniture are in its proper place, in good working condition and clean. Make sure bed is made with clean linen and all space is clean. Check for adequate lighting and provide ventilation. Apply resident's name label on door, etc. as needed.

c. Wash your hands.

d. Identify the new resident by asking his/her name and by checking the identification. Identify yourself. Greet the resident and family courteously. Call resident by proper or preferred name.

e. Take the resident and family to the unit/room.

f. If semi-private room, introduce roommate. Provide privacy by screening unit.

g. Ask the new resident to be seated, or if ordered, help resident undress and assist into bed from stretcher or wheelchair. Adjust side rails.

h. Explain the call bell system and standard regulations. Place call bell within easy reach.

i. Care for clothing and personal articles according to facility policy. Assist with unpacking and labeling clothing. Label all personal articles and store in bedside table (or appropriate place). Be certain resident, if awareness level permits, knows where you place these articles, if not the resident, then a family member.

j. Follow and explain to the resident and family the facility policy for inventory and safekeeping of valuables.
k. Give instructions to resident and/or family as to time and place of meals and, as appropriate, provide other orientation such as facility premises, introduction to other staff, etc.
l. Check the resident's weight and height.
m. Take temperature, pulse, respiration, and blood pressure.
n. Clean and replace equipment according to facility policy.
o. Wash your hands.
p. Make resident comfortable. Place call bell within reach. Leave fresh water if permitted.
q. Record/report completion of procedure. Report to charge nurse: resident's vital signs; any bruises, sores, etc. on the resident's body; any special observations made about the resident.

34. **Feeding a Resident (Requiring Total Feeding):**

a. Identify the resident and explain what you plan to do.
b. Offer the bedpan/urinal before tray time.
c. Wash your hands.
d. Wash the resident's hands.
e. Roll the head of the bed up unless the resident's condition disallows it. Adjust the resident to a comfortable position.
f. Obtain the food tray and check the diet card to be certain that the tray is for the right resident.
g. Place the tray on the overbed table. Remove unnecessary items from the overbed table.
h. Place a napkin under the resident's chin.
i. Tell the resident what is on the tray. Season the food according to resident's taste unless otherwise ordered. Follow the resident's preference for the order in which food is offered.
j. Test the food for temperature. Warn the resident if the food or liquid is hot.
k. Alternate solids and liquids in a manner in which the resident prefers. Feed the resident slowly. Do not offer food until the last bite has been swallowed.
l. Talk to the resident.
m. Allow resident to assist as much as possible.
n. Use napkin to wipe resident's mouth and hands as often as necessary.
o. If the resident is paralyzed on one side, offer the food on the unaffected side of mouth and allow time for swallowing.
p. When serving a liquid with a straw, hold the straw in place while the resident sucks in.
q. Encourage the resident to eat as much as possible without

forcing.

r. Remove tray as soon as resident is finished. Make sure to note what the resident has or has not eaten.
s. Wash the resident's hands and face.
t. Take the tray to the proper place. Return to the room and tidy the bed and overbed table.
u. Wash your hands.
v. Make resident comfortable. Place call bell within reach.
w. Record/report completion of the procedure. Note the amount of food and liquid intake. Note any other observations made about the resident.

35. **Incontinence Care:**

a. Assemble your equipment: Wash basin with warm water, washcloth, hand towel, soap, talcum powder or cornstarch, skin lotion, clean clothes, adult undergarment (optional), clean bed linens, protective pad for bed, disposable gloves, room deodorizers (optional).
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Demonstrate calm, pleasant and matter of fact attitude. DO NOT scold or treat the resident like a child. Provide for dignity of the resident.
f. Put on gloves (optional).
g. Wash and dry all affected skin areas.
h. Remove and dispose of gloves, if used. If gloves were not used, wash hands.
i. Maintain good skin condition by applying powder, cornstarch and lotion as necessary.
j. Assist resident to put on clean, dry clothes. May use adult undergarment.
k. Change bed linens as necessary. Use protective pad on bed.
l. Remove all soiled linen and clothing according to facility policy.
m. Wash your hands.
n. Make resident comfortable. Place call bell within reach.
o. Provide the resident with room deodorizers as needed to assure an odor-free environment.
p. Record/report completion of procedure. Note frequency and character of the bowel movement. Record observations made about the resident's behavior.
q. Check the resident at least every two hours.

36. **Urinary Catheter and Tubing Care:**

a. Assemble your equipment: Basin of water, mild soap or cleaning solution, wash cloth or gauze pads, paper or plastic bag for waste, lotion and/or cornstarch powder, disposable gloves.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.

e. Position the resident on his/her back so the catheter and meatus are exposed.
f. Observe the area around the catheter for lesions (sores), crusting, leakage or bleeding. Report any unusual observations to your charge nurse immediately.
g. Put on gloves.
h. Wash the area gently. Do not pull on the catheter, but hold it with one hand while wiping it with the other.
i. Wipe away from the meatus. Wipe from the meatus to the anus. Wipe one way, not back and forth. Use different area of washcloth or separate gauze pad for each wipe.
j. Remove and dispose of gloves.
k. Dry the area. Apply lotion and/or cornstarch powder to the thighs in small quantities. Ask charge nurse if this area should be kept dry or moist.
l. Make sure the catheter tubing is secured (not pulling on meatus) and draining properly.
m. Dispose of the dirty water into the toilet. Clean equipment and return to its proper place.
n. Wash your hands.
o. Make resident comfortable. Place call bell within reach.
p. Record/report completion of procedure and note any observations made about the resident.

37. **Postmortem Care:**
a. Assemble your equipment: basin of warm water, washcloth, towels, shroud or clean sheet, clean dressings, container for valuables.
b. Wash your hands.
c. Provide for privacy.
d. Remove all equipment and used articles. Check facility policy regarding removal of catheters.
e. Maintain an attitude of respect.
f. Remove all pillows except one under the head. Place the body on the back, head and shoulders elevated. Move the body gently to avoid bruising.
g. Close eyes by grasping eyelashes. Do not press on the eyeballs.
h. Place dentures in the mouth, if possible. If not possible, clean, place in cup and give to the family. Secure jaw if needed.
i. Bath as necessary. Remove any soiled dressings and replace with clean ones.
j. Fold the arms over the abdomen.
k. Put the shroud on the body.
l. Collect all belongings. Wrap and label them. Care for resident's valuables according to facility policy.
m. Wash your hands.
n. Record/report completion of procedure.

38. **Transfer a Resident from Bed to Stretcher:**
   - a. Assemble your equipment: stretcher, bath blanket, sheet, turning sheet (optional).
   - b. Wash your hands.
   - c. Identify the resident and explain what you plan to do.
   - d. Provide for privacy.
   - e. Lock wheels of bed and raise to horizontal position equal to height of stretcher. Lower side rails of bed on the side you are working on.
   - f. Place a sheet or bath blanket over the resident. Working under the sheet or bath blanket, fold the top covers to the foot of the bed. In this way the resident need never be exposed during the move.
   - g. Position stretcher against bed. Lock wheels and lower side rails of stretcher.
   - h. Facing the bed, lean across the stretcher holding it against the bed with your body.
   - i. If resident is able, instruct him/her to slide slowly toward you onto the stretcher, moving hips, then head and shoulders, then legs.
   - j. If resident is unable to help move themselves, enlist help from two other nursing assistants. Position one assistant on opposite side of bed and one at end of bed. The third assistant will be positioned on opposite side of stretcher.
   - k. Roll turning sheet close to resident's body. Assistant on opposite side of stretcher uses both hands to grasp turning sheet. Lift and draw resident onto stretcher. Assistant opposite places one arm for support under head and shoulders of resident and, with the other hand, grasps turning sheet to guide resident. Assistant at foot of bed lifts resident's feet and legs. All assistants must coordinate their activities and move together as signal is given.
   - l. Position resident on stretcher. Place a pillow under the resident's head unless they object or it aggravates condition.
   - m. Tighten stretcher restraints and provide blanket/cover as needed. Raise side rails.
   - n. Transport the resident as directed. Assume a position at the head and push the stretcher.
   - o. Transport the resident to the assigned area. Do not leave the resident alone. Wait until another health care worker assumes responsibility for the resident's care.
   - p. Wash your hands.
   - q. Record/report completion of procedure and note any observations made about the resident.

39. **Range of Motion Exercises:**
   - a. Wash your hands.
   - b. Identify the resident and explain what you plan to do.
   - c. Provide for privacy.
   - d. Prior to starting the procedure, offer the resident the bedpan or urinal.

e. Raise the bed to a comfortable working position. Lower the side rails on the side you are working on.
f. Move the resident close to you. Position yourself close to the resident, using good body mechanics.
g. Place the resident in a supine position with knees extended and arms at side.
h. Proceed with the exercises as you have been instructed. Be sure you have specific instructions as to the type of motions to be carried out.
i. Do not expose the resident unnecessarily during the procedure.
j. Always be gentle as you do each exercise, supporting the area above and below the moving joint. Do not complete an exercise if the resident complains of pain or discomfort or if there is resistance in the joint movement.
k. When finished, lower side rails on bed. Make the resident comfortable. Place call bell within reach.
l. Wash your hands.
m. Record/report completion of the procedure and note any observations made about the resident.

40. Assisting the Resident with a Shower:

a. Assemble your equipment: soap, washcloth, bath towels, bath mat, chair or stool, bath powder (optional), clean clothing (gown, robe, slippers).
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Take supplies to the bathroom and prepare it for the resident. Check the shower and wash it if necessary.
f. Assist the resident to the bathroom and help them to remove robe and slippers.
g. Turn on the shower and adjust water to safe temperature and resident's preference. Check water temperature with hand or elbow before the resident enters shower. The water temperature should be comfortably warm.
h. Assist the resident into the shower. Offer chair/stool, if necessary.
i. Give the resident soap and washcloth so he/she can wash as much as possible. Give the resident as much privacy as is safely possible. Assist as necessary.
j. Turn off the water and assist the resident out of the shower.
k. Assist the resident with drying parts of body they have difficulty reaching. Apply powder if requested or instructed.
l. Help the resident dress as needed.
m. Assist resident back to their room. Make resident comfortable. Place call bell within reach.
n. Return to the shower room. Clean shower and bathroom as necessary. Return supplies to proper place.
o. Wash your hands.
p. Record/report completion of the procedure and note any observations made about the resident.

Difficulty Level V

41. **Assisting Resident to and from Chair/Wheelchair to Bed:**
   a. Assemble your equipment: chair or wheelchair, bath blanket, robe and slippers nearby.
   b. Wash your hands.
   c. Identify the resident and explain what you plan to do.
   d. Provide for privacy.
   e. Cover the chair or wheelchair with bath blanket.
   f. Place chair or wheelchair near the head of bed facing the foot of the bed. Lock the wheelchair and raise foot rest.
   g. Elevate head of bed and lock wheels. Lower the bed to lowest horizontal position.
   h. Drape resident with a bath blanket and fanfold top bedclothes to foot of bed.
   i. Assist the resident to a sitting position by placing one arm around the resident's shoulders. Place the other arm under the resident's knees and pivot (rotate) the resident toward the side of the bed. Remain facing the resident to prevent a fall.
   j. Assist the resident in putting on robe and slippers.
   k. Have resident place feet on floor with both hands on your shoulders. Place your hands on either side of the resident's underarms. Assist the resident to a standing position.
   l. Keeping hands in the same position, help resident to turn slowly until the resident's back is toward the chair.
   m. Lower the resident gradually to a sitting position in the chair, bending at your hips and knees
   n. Make the resident comfortable. If the resident is in a wheelchair, place both feet on the foot rest and lock the wheelchair securely. Cover resident with a bath blanket. Place call bell and drinking water within reach.
   o. Stay with resident until you are sure there are no adverse side affects. Report anything unusual to supervising nurse.
   p. Wash your hands.
   q. Record/report completion of procedure and note any observations made about the resident.

To assist the resident back to bed, just reverse the directions. Your body mechanics and positioning are the same as in helping the resident into the chair.

a. Wash your hands.
b. Prepare the bed. Adjust bed to lowest horizontal position and wheels are locked. Raise head of bed, fanfold top bedclothes to foot of the bed, and raise opposite side rails.
c. Position chair or wheelchair at foot of the bed. Lock wheels of wheelchair and lift foot rest.
d. Remove bath blanket and have resident place feet flat on the floor.
e. Assist resident to a standing position, pivot toward the bed slowly and smoothly. Assist resident to sit on edge of bed.

f. Remove robe and slippers.
g. Assist resident onto center of bed. Lower head of bed and raise side rails.
h. Make resident comfortable. Place call bell within reach.
i. Wash your hands.
j. Record/report completion of procedure and note any observations made about the resident.

42. **Giving a Bed Bath:**
a. Assemble your equipment: soap and soap dish, washcloth, wash basin, face towels, bath towels, bath blanket (optional), clean gown or clothing, talcum powder or cornstarch (optional), lotion, comb or hairbrush, items for nail care, items for oral hygiene, disposable gloves (if indicated), clean bed linen.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Offer bedpan or urinal. Empty and clean before proceeding with bath. Wash hands.
f. Make sure any windows or doors are closed to prevent chilling the resident.
g. Take everything to the bedside before starting the procedure. Put towels and linen on chair in order of use.
h. Raise the bed to a comfortable working height with the side rail up on the side opposite from where you are working. Lower the headrest and kneerest of the bed, if permitted. The resident should be as flat as is comfortable and permitted.
i. Remove and fold blanket and spread leaving the resident covered with bath blanket. Place folded blanket and spread over back of chair. Leave one pillow under resident's head.
j. Assist resident to move closer to you so you can work easily without straining your back.
k. Remove the gown, but keep the resident covered to avoid chilling.
l. Fill the wash basin 2/3 full of water at 105 degrees F.
m. Put a towel across the resident's chest and make a mitt with the washcloth. Wash the eyes from the nose to the outside of the face. Wash the face (use soap at resident's preference, being careful not to get soap in resident's eyes) neck and ears. Rinse and dry gently with bath towel. Rinse washcloth. Apply lotion/cream as needed.
n. Expose resident's far arm. Protect bed with bath towel placed underneath arm. Wash, rinse and dry arm and hand. Be sure armpit is clean and dry. Apply deodorant and powder if resident needs them or request them. Repeat for other arm.
o. Place the basin of water on the towel on the bed. Put the resident's hand into the water. Wash, rinse, and dry the hand well. Provide fingernail care.
p. Put bath towel over resident's chest, and then fold blanket to waist. Under towel, wash, rinse and dry chest. Rinse and dry

folds under breasts of female resident carefully to avoid irritating skin. Use powder/lotion as needed..

q. Fold the blanket down to the pubic area and wash resident's abdomen. Be sure to wash the naval and any creases of the skin. Dry the abdomen, then pull the blanket up over the abdomen and chest and remove the towel.
r. If necessary, empty the dirty water. Rinse the basin and fill it with clean water (105 degrees F).
s. Fold the blanket back from the resident's leg farthest from you. Bend the knee, and wash, rinse and dry the leg and foot. If the resident can easily bend the knee, put wash basin on towel and place resident's foot directly into the basin to wash it.
t. Observe the toenails and the skin between the toes. Look for redness and cracking. Care for toenails as necessary. Remove the wash basin and dry the leg and foot and between the toes. Cover the leg and foot and remove the towel. Repeat the entire procedure for the other leg and foot.
u. If necessary, empty the dirty water. Rinse the basin and fill with clean water (105 F).
v. Assist resident to turn on side away from you and to move toward center of bed. Place towel lengthwise next to resident's back. Wash , rinse and dry neck, back and buttocks. Use long firm strokes when washing back.
w. A back rub is usually given at this point. Look for reddened areas and other skin conditions. Remove towel, apply powder/lotion as needed, and assist resident to turn over.
x. Place towel under buttocks and upper legs. Offer the resident a soapy washcloth to wash the genital area. Offer a clean wet washcloth to rinse with, and a dry towel for drying. If the resident is unable to do this, you must wash for them. Allow privacy at all times. Put on gloves when washing the genital area (remove gloves when completed).
y. Cover pillow with towel and comb or brush resident's hair. Oral hygiene is usually given at this time.
z. Follow the procedures for dressing the resident and transferring to a wheelchair (if instructed). If resident is to remain in bed, put a clean gown on the resident.
aa. Change the linens and make the bed.
ab. Dispose of used towels, washcloths and dirty linen in appropriate place. Clean your equipment and put it in its proper place. Discard disposable equipment.
ac. Make resident comfortable. Raise side rails. Place call bell within reach. Leave room/unit orderly.
ad. Wash your hands.
ae. Record/report completion of procedure and note any observations about the resident.

43. Assisting the Resident with a Tub Bath:

a. Assemble your equipment: soap, washcloth, towels, bath thermometer (if available), chair, bath mat, powder, lotion,

clean clothing, disinfectant solution.
b. Take supplies to the tub/bath room and prepare it for the resident. Make sure tub is clean (use disinfectant solution).
c. Wash your hands.
d. Identify the resident and explain what you plan to do.
e. Take the resident to the tub room, being sure that he/she is covered to avoid chilling. Provide for privacy.
f. Fill the tub half full of water at 105 degrees F. Test temperature with a bath thermometer, if available, or by touch.
g. Place a towel on the floor where the resident will step out of the tub to prevent slipping. Have a towel or mat in bottom of the tub to prevent slipping.
h. Assist resident to undress and get into the tub. Get additional assistance if necessary.
i. Let the resident stay in the tub according to your instructions (usually about 15 minutes). Assist the resident with washing as needed. Never leave the resident alone in the tub.
j. Assist the resident out of the tub, holding bath blanket around the resident, and onto the towel-covered chair. Assist in drying as needed. Apply powder/lotion as needed.
k. Assist the resident to dress and return to the room/unit.
l. Make the resident comfortable. Place call bell within reach.
m. Return to the tub room. Clean the tub (use disinfectant). Dispose of used towels, washcloths, and dirty clothes in appropriate place. Return supplies to proper place.
n. Wash your hands.
o. Record/report completion of procedure and note any observations made about the resident.

44. Feeding with an Asepto Syringe:

a. Assemble your equipment: food tray, syringe, water, washcloth, swabs.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Raise the bed to a 45 degree angle.
f. Provide washcloth for the resident to wash hands and face if physically able. Assist as necessary.
g. Obtain food tray and check the diet card to make sure the tray, diet and resident's name are correct. Place tray on overbed table.
h. Place a napkin under the resident's chin.
i. Moisten lips or mouth with a dampened swab.
j. Place small amounts of one type of food at a time in the syringe.
k. Be aware that communication is necessary. Tell the resident the food contents of the syringe.
l. Test the temperature of the food before placing in resident's mouth.
m. Place the tip of the syringe between the gums and cheek, not

on the tongue.

n. If the resident is paralyzed on one side, offer the food on the unaffected side of mouth and allow time for swallowing.
o. Feed slowly. Be sure all food is swallowed before giving more.
p. Alternate small amounts of food with small amounts of water. When serving liquid with a straw, hold the straw in place while the resident sucks in.
q. Provide as normal an environment as possible to meet total resident needs.
r. Remove the tray as soon as the resident has finished. Make sure to note what the resident has or has not eaten.
s. Wash the resident's hands and mouth.
t. Take the tray to the proper place. Return to the room and tidy the bed and overbed table.
u. Make the resident comfortable. Place call bell within reach.
v. Wash your hands.
w. Record/report completion of the procedure. Record the type and amount of food eaten. Note any other observations made about the resident.

45. **Isolation Technique - Preparing the Unit:**

a. Isolation is an infectious disease control process and will be carried out according to facility policy and specific technique for a specific disease. Check instructions from the charge nurse.
b. Assemble your equipment: caution sign, cart, disposable masks, disposable gloves, gowns, wastebasket liners, bags (to dispose of contaminated materials), linen bags marked "isolation", resident needs (bath articles, toilet articles), thermometer, antiseptic solution, etc.
c. Wash your hands (even more frequent handwashing is a necessity for isolation technique).
d. Place a "Barrier", "Isolation", or "Precaution" sign on the door.
e. Place a cart or bedside table beside the door and supply it with: isolation gowns, caps, gloves, and masks as ordered; plastic bags; linen/laundry bags specially marked as "isolation".
f. Follow isolation instructions prior to entering resident's unit/room.
g. Place all resident care equipment in the usual resident unit places.
h. Line wastebasket with a plastic bag.
i. Supply a laundry hamper with a linen/laundry bag specially marked "isolation".
j. Put antiseptic solution dispenser over or near sink.
k. Check supply of paper towels and liquid soap.
l. Place a basin of disinfectant solution for soaking contaminated articles near the sink.
m. Follow isolation instructions as you leave the resident's

unit/room.
n. Wash your hands.
o. Record/report completion of the procedure and note observations made about the resident.

Isolation Technique - Handwashing:

a. Assemble your equipment: soap or detergent, waste can, paper towels, nail brush.
b. Open a paper towel near the sink. This is considered your clean area. Put all your equipment on it. Leave it there until you are ready to leave the room.
c. Turn on the faucet with a paper towel held between the hand and the faucet. Drop the paper towel into the waste can.
d. Wet your hands and wrist under the running water. Keep your fingertips pointed downward.
e. Apply soap or skin cleanser to hands.
f. Hold your hands downward and lower than your elbows while washing.
g. Work up a good lather. Spread it over the entire area of your hands and wrist (two inches above the wrist). Get soap under your nails and between your fingers. Add water while washing.
h. Use a rotating and rubbing (friction) motion for one full minute:
   -rub vigorously.
   -rub one hand against the other hand and wrist.
   -rub between your fingers by interlacing them.
   -rub up and down to reach all skin surfaces on your hands and between your fingers.
   -rub the tips of your fingers against the palms to clean with friction around the nail beds.
   -use the nail brush on your nails.
   -wash at least two inches above your wrist.
i. Rinse thoroughly from wrist to fingertips, keeping fingertips down.
j. Dry hands and wrist thoroughly with a paper towel.
k. Use a paper towel to turn off the faucet.
l. Discard the paper towel into the waste can.
m. Do not touch the waste can.
n. Do not touch the inside of the sink with clean hands.
o. Do not lean against the sink or splatter uniform.

Isolation Technique - Mask, Gown, and Gloves:

a. Assemble your equipment: mask, gown, gloves, plastic bag, paper towel.
b. Remove any rings and secure them inside uniform pocket.
c. Remove watch and place in a plastic bag or on a clean paper towel.
d. Wash your hands.
e. Adjust mask over nose and mouth and tie securely.
f. Unfold the isolation gown so that the opening is at the back. If you are wearing a long-sleeved uniform, roll your sleeves

above your elbows.

g. Put on gown, slipping arms into sleeves. Fit the gown at the neck, making sure your uniform is covered. Reach behind and tie the neck back with a simple bow or fasten the adhesive strip. Reach behind and overlap the edges of the gown to cover uniform completely. Secure ties in a bow or fasten adhesive strip.

h. Obtain and place plastic gloves in front of you on table so thumbs are pointing in opposite directions. Make a cuff on each glove. Slip fingers into left glove, easing glove over hand and fingers as you pull glove on with opposite hand. Pick up right glove with left hand by slipping fingers of gloved hand under the cuff. Insert right hand into glove, spreading fingers slightly to slide into proper areas. Adjust gloves by interlacing fingers.

i. Upon completion of resident care, remove contaminated gloves, mask and gown.

j. Remove gloves, turning them inside out (slip gloved fingers of right hand under cuff of opposite hand, touching the glove only. Pull glove down to fingers, exposing thumb. Slip uncovered thumb into opposite cuff. Pull glove down over right hand. With right hand touching the inside of the left glove, pull down over the left hand). Dispose of gloves according to facility policy.

k. Undo waist ties and loosen gown at waist.

l. Turn on faucets, holding a clean paper towel. Discard paper towel in waste can.

m. Wash hands carefully and dry with paper towel. Dispose of paper towel. Turn off faucet with a paper towel. Dispose of paper towel.

n. Using paper towel to operate dispenser, wet hands with antiseptic and rub together. Air dry.

o. Undo mask. Holding by ties only, deposit in proper container.

p. Undo neck ties and loosen gown at shoulders.

q. Slip fingers of the right hand inside the left cuff without touching the outside of the gown. Pull gown down and over the left hand. Pull gown down over the right hand with the gown-covered left hand.

r. Fold gown with contaminated side inward. Roll and deposit in laundry bag or waste container, if disposable.

s. Rewash hands using same technique.

t. Remove watch from plastic bag or paper towel. Dispose of paper towel.

u. Open door with clean paper towel. Prop door open with foot and drop paper towel in waste can.

46. **Making an Occupied Bed:**

a. Assemble your equipment: cotton draw sheet or turning sheet for selected residents, bed protectors (if used), bath blanket (if available), pillow cases, regular and fitted sheet, bedspread, blanket, container for dirty linen.

b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Place bedside chair at foot of bed. Place linen/supplies on chair in order of use.
f. Adjust the bed to a flat position (unless otherwise indicated) and lock wheels. Raise to comfortable working horizontal height.
g. Loosen all sheets around the entire bed.
h. Take the bedspread and blanket off the bed and fold them over the back of the chair. Leave the resident covered with top sheet or bath blanket.
i. Raise the side rail on the opposite side from where you will be working.
j. Turn the resident to the side toward the raised rail, with a pillow under the head. Assist as necessary.
k. Fold the cotton draw sheet toward the resident and tuck it against resident's back. Protect resident from any soiled matter on the bed.
l. Raise the plastic draw sheet (if it is clean) over the bath blanket and the resident.
m. Roll the bottom sheet toward the resident and tuck it against his/her back. This strips your side of the bed down to the mattress.
n. Take the large clean sheet and fold it in half lengthwise. Do not permit the sheet to touch the floor or your uniform.
o. Place it on the bed, still folded, with the fold running along in the middle of the mattress. The small hem end of the sheet should be even with the foot edge of the mattress. Fold the top half of the sheet toward the resident (this is for the other side of the bed). Tuck the folds against the back, below the plastic draw sheet.
p. Tuck the sheet around the head of the mattress by gently raising the mattress with the hand closest to the foot of the bed and tucking with the other hand.
q. Miter the corner at the head of the mattress. Tuck in the bottom sheet on your side from head to foot of the mattress.
r. Pull the plastic draw sheet toward you, over the clean bottom sheet and tuck in.
s. Place the clean cotton draw sheet over the plastic sheet, folded in half. Keep the fold near the resident. Fold the top half toward the resident, tucking the folds under resident's back, as you did with the bottom sheet. Tuck the free edge of the draw sheet under the mattress.
t. Have the resident roll over the "hump" onto the clean sheets facing toward you. Assist as necessary.
u. Raise the side rail on your side of the bed and lock in place.
v. Go to the other side of the bed and lower side rail.
w. Remove the old bottom sheet and cotton draw sheet from the bed. Put them into the container for dirty linen. Pull the fresh bottom sheet toward the edge of the bed. Tuck it under

the mattress from the head to foot. Do this by rolling the sheet up in your hand toward the mattress and pull it as you tuck it under.

x. One at a time, pull and tuck each draw sheet under the mattress.
y. Have the resident turn on his/her back. Assist as necessary.
z. Change the pillowcase and place under the resident's head.
aa. Be sure side rails are up and secure. Lower bed to lowest horizontal position. Replace bedside table and chair. Remove dirty linen according to facility policy.
ab. Make the resident comfortable. Place call bell within reach.
ac. Wash your hands.
ad. Record/report completion of the procedure and note any observations made about the resident.

47. **Oral Hygiene for the Unconscious Resident:**

a. Assemble your equipment: towel, emesis basin or small basin, disposable gloves, mouth care kit of commercially prepared swabs, or if such kit is not available obtain; tongue depressor, applicators or gauze sponges, lubricant such as glycerine, or a substance used by your facility, or a solution of lemon juice and glycerine.
b. Wash your hands.
c. Identify the resident and explain what you plan to do. Even though a resident seems to be unconscious, he/she may still be able to hear you.
d. Provide for privacy.
e. Stand at the side of the bed and turn the resident's face toward you.
f. Support the resident's face on a pillow covered by a towel.
g. Put the emesis basin (or small basin) on the towel under the resident's chin.
h. Put on your gloves.
i. Place the mouth care equipment near you so you do not have to move.
j. Press on the cheeks and hold the tongue in place with a tongue depressor.
k. Open the commercial package of swabs (if commercial swab is not available, use applicators moistened with solution) and wipe the resident's entire mouth, roof, tongue, and inside the cheeks and lips. Put the used swabs in the basin.
l. Dry the resident's face with a towel. Using a clean applicator, put a small amount of lubricant on the resident's lips.
m. Clean your equipment and put it back in proper place. Discard disposable equipment in the proper container.
n. Remove your gloves.
o. Make the resident comfortable. Place call bell within reach.
p. Wash your hands.
q. Record/report completion of the procedure and note any observations made about the resident.

48. Using a Portable Mechanical Resident Lift:

SPECIAL NOTES:

- Never operate a mechanical lift without the assistance of another staff person. Safety requires two people.
- Lock all brakes after positioning lift.
- Check slings and straps for frayed areas or poorly closing clasps.
- Be sure that all locks and straps are fastened securely.
- Reassure resident while moving. Falling is a great fear of residents so be aware of this fact.

a. Assemble your equipment: mechanical lift, sling, blanket or sheet.
b. Wash your hands.
c. Identify the resident and explain what you plan to do.
d. Provide for privacy.
e. Place wheelchair or chair at right angles to foot of bed, facing head of bed. Cover the chair with blanket or sheet.
f. Take lift to resident's bedside. Lock wheels on bed.
g. Roll resident toward you and slide the sling under the resident. Position sling beneath body behind shoulders and buttocks. Be sure that sling is smooth and positioned properly..
h. Attach suspension straps to sling. Check fasteners for security.
i. Position lift frame over bed with base legs in maximum open position and lock.
j. Elevate head of bed and bring resident to semi-sitting position.
k. Attach suspension straps to frame (attach the sling to the lift with the hooks in place facing out). Position resident's arms inside straps. Secure restraint straps, if needed.
l. Have resident fold both arms across chest, if possible. Using the crank, slowly lift resident from the bed. Talk to the resident to comfort them.
m. Guide lift away from the bed. Guide the resident's legs.
n. Position the resident close to chair or wheelchair (with wheels locked). Slowly lower resident into chair or wheelchair. Pay particular attention to the position of the resident's feet (guide the resident's legs).
o. Unhook suspension straps and remove lift.
p. Leave the resident safe and comfortable in the chair for the proper amount of time, according to your instructions.
q. Wash your hands.
r. To get the resident back into the bed, rehook suspension straps (place the hooks facing out) which are still under the resident.
s. Raise the resident by using the crank on the mechanical lift. Lift resident from the chair into the bed. Have your partner guide the resident's legs. Lower resident into the center of the bed.
t. Remove the hooks from the frame. Remove the sling from under

the resident by turning the resident from side to side (assist as necessary).

u. Remake the top of the bed. Put a pillow under the resident's head. Properly position the resident. Raise side rails.

v. Make resident comfortable. Place call bell within reach.

w. Record/report completion of the procedure and note any observations made about the resident.

ABRIDGED GLOSSARY

abuse/maltreatment	- any willful or negligent act which results in an injury or damage.
active exercise	- exercise the resident does for self.
activities of daily living	- needs of the resident for daily care.
admission procedures	- measures taken when a person enters a long term care facility.
aging process	- changes in the body caused by growing older.
ambulatory	- able to walk.
apathy	- lack of interest or concern.
appetizing	- food that looks appealing.
asepsis	- state of being free of pathological organisms.
aspiration	- materials/particles drawn into the lungs on inspiration.
assault	- threat or attempt to injure another in an illegal manner.
attitude	- a mood or feeling; mental position with regard to a fact or state.
axillary	- arm pits; area under the arms.
bacteria	- germs, microscopic organisms.
base of support	- part of the body that bears the most weight.
battery	- physical abuse to resident; unlawful touching of another person with consent, with or without resulant injury.
behavior	- non-verbal and/or verbal expression of thoughts and feelings.
blood pressure	- refers to two different pressures in the blood system; systolic pressure (heart contracts) and diastolic pressure (heart in full relaxation).

ABRIDGED GLOSSARY

body alignment	- arrangement of the body in a straight line.
body language	- gestures that function as a form of communication.
body mechanics	- proper use of the human body to do work to avoid injury and strain.
catheter	- a tube which is used to withdraw fluid from a body cavity.
charge nurse	- the nurse who has the total responsibility for residents during the tour of duty.
chronic	- marked by long duration; frequent reoccurences; not acute.
chronological	- relating to arranged in/or according to the order of time.
cognition	- process involved in knowing.
coma (unconscious)	- lack of awareness; not able to respond, but possible can hear.
communicate	- exchange of ideas between two or more people.
comprehension	- to understand.
conduct	- the way you do things.
confidentiality	- containing information whose unauthorized disclosures could be harmful.
confusion	- clouding of level of thoughts.
conscious	- state of awareness.
consent	- permission granted voluntarily by a person in his/her right mind.
contagious	- easily transmitted by contact.
contaminated	- soiled; contains microorganisms (germs).
contractures	- shortening of tissue causing deformity or distortion. Ex. muscle.

ABRIDGED GLOSSARY

constipation	failure of bowels to excrete residue at proper intervals.
convulsion	temporary loss of conscious with severe muscle contractures; fit or generalized spasm.
corn	thickening of the skin, hard or soft, according to location on the foot.
cyanosis	blue/gray color or the skin, lips and/or nailbeds.
death	the end of life; permanent cessation of vital body functions.
decubitus ulcer	pressure sore; bed sore; tissue breakdown.
defamation of character	making damaging or false statements about another person which injures the reputation.
deformity	malformation.
dehydration	there is not a sufficient amount of fluid in the body.
delirium	mental disturbance usually occuring in the course of some infectious disease or under influence of poisonois drugs.
denial	refusal to admit the truth or reality.
dependability	reliable; capable of being depended on.
depression	feeling of dejection which can be characterized by anxiety discouragement or of inadequacy.
diagnosis	determination of a resident's disease (made by the physician).
diarrhea	water, loose bowel movement (feces).
diastolic	period of relaxation of the heart during which it fills with blood; last thump sound heard when taking blood pressure (bottom reading).

ABRIDGED GLOSSARY

diet	- the prescribed allowance of food ordered by the resident's physician.
diabetic	- a person who has a disease of the pancreas which does not produce sufficient amounts of insulin.
discharge procedures	- measures taken when a resident leaves a long term care facility.
disinfection	- killing germs by antiseptics or other methods.
disease	- sickness; illness.
disorientation	- confusion of time, place, person.
edema	- abnormal swelling of a part of the body caused by fluid collecting in that area
elimination	- discharge of waste products from the body by the skin, by the kidneys, by respiration and/or by the intestines.
emotion	- subjective feelings; ex. hate, anger, love, joy, sadness.
empathy	- understanding; feeling for but not as another feels.
ethics, nursing	- system of moral principles governing nursing conduct.
excrement	- feces; product of lower intestinal tract; bowel movement.
exploit	- to take advantage of.
extremity	- a limb of the body.
fever	- elevation of body temperature.
flex	- to bend.
fragile	- easily broken or destroyed; weak.
frustration	- an emotion sensation that develops when an individual is prevented from reaching a goal.

ABRIDGED GLOSSARY

goal	the end toward which effort is directed/aimed.
grooming	appearance of the resident.
hallucination	a mistaken sense impression. Any of the five senses can be involved - most frequent is the auditory (hearing).
harrassment	mental and emotional abuse. It can be verbal and/or non-verbal.
hierarchy	a graded or ranked series.
health	state of well-being of physical; mental, social and/or spiritual well-being.
health team	made up of all the people who provide services for the residents. The nursing assistant is a vital part of this health team.
hygiene	conditions of practices conductive to health.
hyper-	high.
hypo-	low.
illness	poor health of mind and/or body; presence of disease.
impaction	firmly wedged in.
impairment	to make worse or diminish in some material respect.
impending	probably will happen soon.
incompetence	legal term: individual is unable to handle his personal affairs due to mental impairment.
infection	implantation of germs; spread of disease.
infirmity	weakness, sickness.

ABRIDGED GLOSSARY

inflammation	- changes that occur in living tissues when invaded by germs. e.g., redness, swelling, heat and pain.
influenza (flu)	- virus infection.
intake	- fluids that enter the body.
integrity	- soundness, honesty.
integumentary system	- protective covering of the body; skin, hair, nails.
intestine	- digestive tract beginning at the mouth and ending at the anus.
invasion of resident privacy	- public knowledge of a resident's information without consent of wronged resident.
isolation technique	- a method of keeping disease (germs) from spreading; to set apart from others.
jaundice	- yellow tinge to skin, membranes and eyes.
kidney	- organ which secretes urine.
legible	- easy to read; clear.
libel	- a written or oral defamatory statement or representation that conveys an unjustly unfavorable impression.
long term care facility	- a health facility which provides skilled or intermediate nursing care and supportive care on a 24-hour basis to residents whose primary need is for availability of nursing care on an extended basis.
masturbation	- self-stimulation of the genital area.
muscle	- bundle of contractile fibers which produce movement.
need	- a condition of unsatisfied motives.

ABRIDGED GLOSSARY

negligence	- failure to use the care that a reasonable prudent and careful person would use in a similar situation.
nutrition	- the process of taking in and utilization of food substance.
obese	- overweight.
occlude	- to obstruct or to block.
organic disease	- a disease associated with observable or detectable changes in the organs or tissues of the body.
ostomy	- artifically created opening through the abdominal wall that provides a way for the intestinal organs to discharge waste products.
output	- fluids discharged by the body.
pallor	- paleness, especially of the face.
paralysis	- loss of power of movement in one or more parts of the body.
paralyze	- to cause loss of muscle control and/or feeling.
passive exercise	- exercise that the resident cannot do for self and must done for the resident.
physical findings	- normal, not diseased; concerning body functions.
policy	- a definite course of action planned by management.
positioning	- arranging.
procedure	- a series of steps followed in a regular, definate order.
prosthesis	- body part that is artificial.
range of motion	- exercises which take a body part through the entire ability of its motion.

ABRIDGED GLOSSARY

reality	- the environment as it really exists; a real event or state of events.
reality orientation	- awareness of environment and self to time, place, person.
recall	- remembering a past experience.
respiration	- breathing.
responsibility	- moral, legal, or mental accountability; something for which a person is responsible.
restraint	- any device or instrument used to limit, restrict, or hold resident under control; device or method used to keep a resident from injuring self.
rheumatism	- pain, swelling and deformity of joints of unknown cause.
rigidity	- stiffness.
role	- a behavioral pattern determined by an individual's status in a particular position; roles have specific behavior associated with them.
saliva	- fluid secreted by the glands of the mouth.
scalp	- part of the human head covered with hair.
secrete	- to deposit.
self-abuse	- self-deception.
self-neglect	- failing to care for or about one's self.
sensitive	- easily hurt emotionally; aware of attitudes and feelings of others.
socialization	- learning to live together in a group with other human beings.
stethoscope	- instrument used to listen to sounds of the body.
stimulate	- arouse.

ABRIDGED GLOSSARY

stoma	- artificially made opening connecting a body passage with the outside.
stress	- a physical, chemical, or emotional factor that causes bodily or mental tension and may be a factor in causing disease.
sympathy	- understanding; feeling as another feels; a feeling of sorrow for another.
symptoms	- something that indicates the presence of bodily disorder.
systolic	- period during which no contraction of heart takes place; the first sound heard when taking blood pressure (top reading).
therapeutic	- an act which helps in the treatment of disease or discomfort.
transfer procedures	- measures taken when a resident is moving from one room to another or to another facility.
urine	- liquid wastes discharged by the kidneys.
vertigo	- dizziness
vital signs	- temperature, pulse, respiration, blood pressure.
void	- to urinate, to pass water.

COMMON MEDICAL ABBREVIATIONS

Time Abbreviations

a.m.	-morning	stat	-immediately
p.m.	-afternoon or evening	noc	-night
a.c.	-before meals	P.R.N.	-whenever necessary
p.c.	-after meals	q.d.	-every day
B.I.D.	-twice a day	q.h.	-every hour
T.I.D.	-three times a day	q.o.d.	-every other day
Q.I.D.	-four times a day	q3h	-every three hours
H.S.	-bedtime (hour of sleep)	q4h	-every four hours

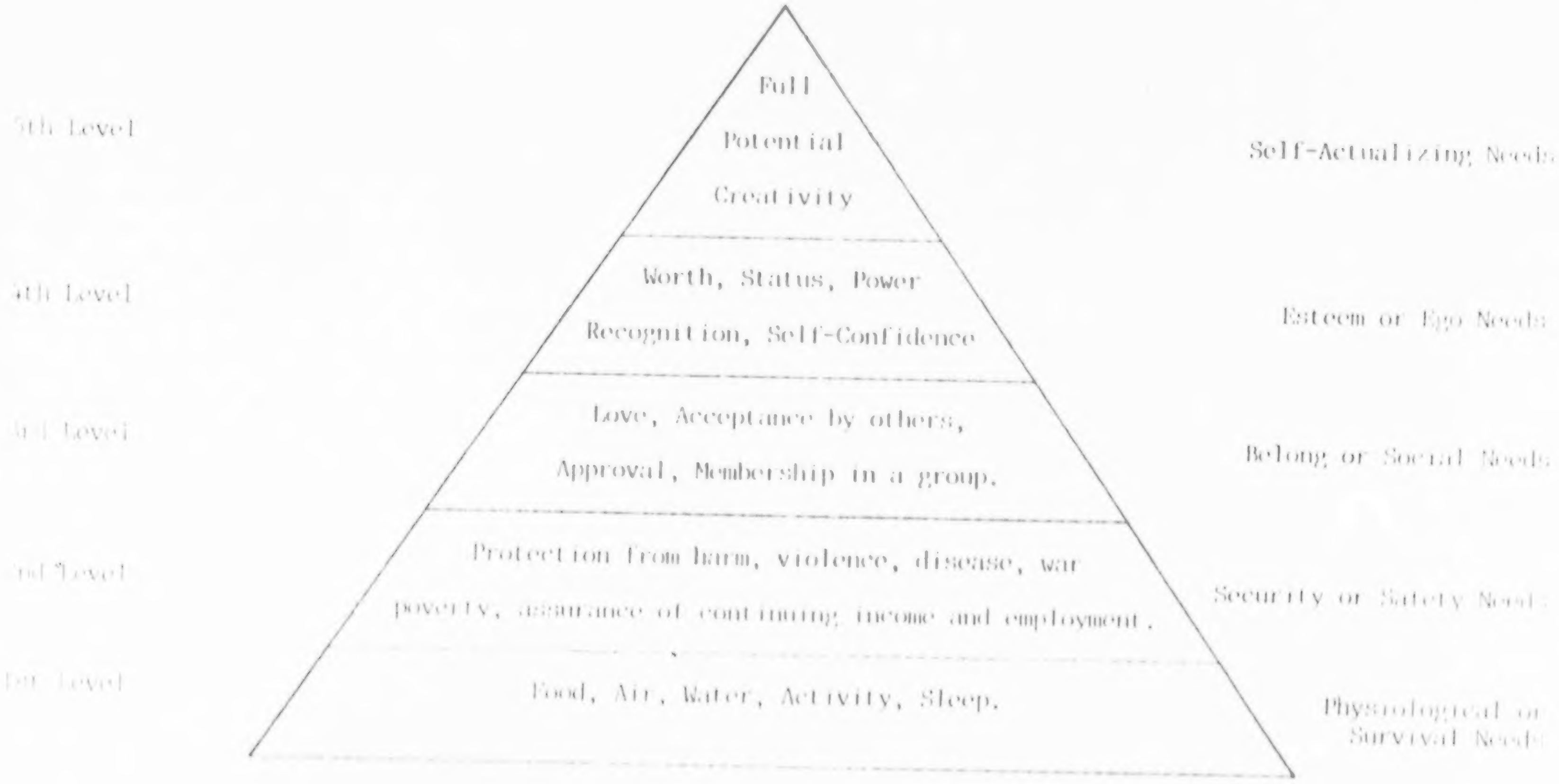
Resident Orders

amt	-amount	NPO	-Nothing by mouth (sometimes NBM)
ax	-axilla		
BM	-bowel movement	P.T.	-physical therapy
BRP	-bathroom priveleges	R	-rectal or right
c	-with	ROM	-range of motion
s	-without	spec.	-specimen
ad lib	-as desired	T.W.E.	-tap water enema
Dc	-discontinued	S.S.E.	-Soap suds enema
ht	-height	w/c	-wheelchair
wt	-weight	TPR	-temperature,pulse, respiration
I&O	-Intake and Output		
BP	-blood pressure	ADL	-activities of daily living
V.S.	-vital signs (TPR & BP)		

Diagnostic Terms

MI	-Myocardial infarction (heart attack) or mental illness	GI	-gastro intestinal
		GU	-genito-urinary
CVA	-cerebrovascular accident or stroke	CHF	-congestive heart failure
H.O.H.	-hard of hearing	Ca	-cancer
S.O.B.	-short of breath	CV	-cardiovascular
fx	-fracture		

MASLOW'S HIERARCHY OF NEEDS


5th Level
Full
Potential
Creativity
Self-Actualizing Needs
4th Level
Worth, Status, Power
Recognition, Self-Confidence
Esteem or Ego Needs
3rd Level
Love, Acceptance by others,
Approval, Membership in a group.
Belong or Social Needs
2nd Level
Protection from harm, violence, disease, war
poverty, assurance of continuing income and employment.
Security or Safety Needs
1st Level
Food, Air, Water, Activity, Sleep.
Physiological or
Survival Needs

BEST COPY AVAILABLE

REFERENCES

The following is a list of references which were consulted in the development of the Arkansas Long Term Care Facility Nursing Assistant Training Program. This is not intended to be a complete listing of all texts consulted.

References used in the development of these guidelines were textbooks and current nursing assistant training curriculums, including the Kansas Adult Care Nursing Home Aide Curriculum.

Being a Long-Term Care Nursing Assistant, 1983.
Robert J. Brady Company
Bowie, MD 20715

Being a Nursing Assistant, Third Edition, 1982.
Schneidman, Rose. et al.
Robert J. Brady Company
Bowie, MD 20715

Being a Nursing Assistant, Fourth Edition.
Schneidman, Rose B., R.N., M.S. Ed., C.N.A. and Lambert, Susan S., M.A. Ed.
The Brady Company
Prentice-Hall
Englewood Cliffs, NJ 07632

Care of Alzheimer's Patients: A Manual for Nursing Home Staff. Chicago: Related Disorders Association, Inc., 1985.
Gwyther, Lisa
American Health Care Association, 1985.

Care of the Older Adult, Second Edition.
Birchenall, Joan M. and Streight, Mary.
J.B. Lippincott Company
301 S. Benton Street
Edwardsville, IL 62025

Essentials of Psychiatric Nursing, C. V. Mosby Co., St. Louis, Missouri 1970.
Mereness, Dorothy, R.N., Ed.D.

How to Be a Nurse's Aide in a Nursing Home, 1985.
Johnson-Paulson, Jean, RN-C, MSN and Goodwin, Marsha, RN-C, MSN, MA.
American Health Care Association
1200 15th Street N.W.
Washington D.C. 20005

REFERENCES

Introduction to Rehabilitation, Arkansas League for Nursing Workshop Series 1970.
Garner, June, BSN, MA.
Arkansas League for Nursing
1700 West Thirteenth Street
Suite 469
Little Rock, AR 72202

The Merck Manual, Fourteenth Edition, 1982.
Merck, Sharp and Dohne
Research Laboratory
Rohway, NJ

The Nursing Assistant
Brooks, Lucy R.N.
Delmar Publishers
Albany, NY 12205

Nurse Assistant in a Long Term Care Facility, Practical Arts and Vocational-Technical Education, Instructional Materials Laboratory.
University of Missouri
Columbia, MO 65211

The Nursing Assistant in Long Term Care, Second Edition, 1980.
Fasano, Marie A.
Inter Age
P. O. Box 60728
Sacramento, CA 95825

The Nursing Assistant in Long-Term Care, A New Era, The C. V. Mosby Co., 1980.
Walston, Betty J., R.N., B.S., M.S. and Walston, Keith K., B.S., M.S.

Nursing Assistant Training Manual, Medi-Form.
Medi-Form
Printers and Publishers, Inc.
5150 S. W. Griffith Drive
Beaverton, OR 97005

The Nursing Process in Later Maturity, 1980.
Murray, Ruth Beckman, et al.
Prentice-Hall, Inc.
Englewood Cliff, NJ 07632

Nursing Skills for Allied Health Services, Volumes 1 and 2, Second Edition, 1977.
Wood, Lucille A. and Rambo, Beverly J.
W. B. Saunders Company
West Washington Square
Philadelphia, PA 19105

REFERENCES

On Death and Dying; Macmillan Publishing Co., New York. 1976.
Kubler-Ross, Elizabeth, M.D.
Personal Care Aide Training
East Arkansas Area on Aging
P. O. Box 5035
Jonesboro, AR 72403-5035

Psychiatric Nursing, C. V. Mosby Co., 1961.
Matheney, Ruth, R.N., Ed.D. and Topalis, R.N., B.S., M.A.

Psychiatric Nursing, F. A. Davis Co., 1977.k
Manfreda, M., R.M., MA, and Krampitz, S.

Realities and Resources; Vision Loss and Aging, Trainers Manual
Contract Division of Aging and Adult Services
(501) 682-2441

Sensitizing People to the Process of Aging: The In-Service Educator's Guide, 1975.
Erst, Marvin and Shore, Herbert.
Centers for Studies on Aging
The School of Community Service
North Texas State University
Enton, TX 76203

COMMITTEE
FOR
ARKANSAS LONG TERM CARE FACILITY NURSING ASSISTANT TRAINING CURRICULUM

NELL T. BALKMAN, RN, Retired
North Little Rock, Arkansas

Education:

Henderson State University, Arkadelphia, Arkansas
Bachelor of Arts

Vanderbilt University, Nashville, Tennessee
Bachelor of Science in Nursing

Experience:

Supervisor, Nursing Administration, Geriatrics Areas
Fort Roots Veterans Administration Hospital

Senior Instructor, Nursing Education, Registered Nurse Student
Psychiatric Nursing Affiliation

Director, Continuing Education
Arkansas League for Nursing

Organizations:

American Nurses Association

Arkansas State Nurses Association

National League for Nursing

Arkansas League for Nursing

Arkansas Nursing Home Nurses Association

American Association of Retired Persons

RUTH ERLENE HAMILTON, RN
Mountain Home, Arkansas

Education:

Bethel Deaconess Hospital, Newton, Kansas
Diploma Nurse

CURRICULUM COMMITTEE

Eastern Mennonite College Harrisonburg, Virginia
Bachelor of Science in Nursing

Experience:

Patient Care Coordinator
Baxter Manor Nursing Home

Supervisor and Teacher
Promise Land Academy

Director of Nursing
Baxter Manor Nursing Home

Director of Nursing
Baxter General Hospital

Director of Nursing
Marion County Hospital

Surgical Floor Nurse and In-Service Education Director
Boone County Hospital

Organizations:

Advisory Council Practical Nurses School
Twin Lakes Vocational Technical School of Mountain Home, Arkansas

Arkansas Nursing Home Nurses Association

JOYCE T. JONES
Little Rock, Arkansas

Education:

University of Arkansas at Little Rock
B.A., Sociology/Gerontology, 1974
State of Arkansas Licensed Social Worker

Experience:

Program Supervisor, Division of Aging and Adult Services. Planning and program development for Alternatives Services in Long Term Care and case management since 1976.

Organizations:

Central Arkansas Alzheimer's Disease and Related Disorder Association Board since 1984.

CURRICULUM COMMITTEE

Southwest Society on Aging

Arkansas Gerontological Society

Little Rock Women's City Club

Ad Hoc Committee on Women's Concerns, Association of Area Agencies on Aging

PEGGY MOODY, RN, ADM
Carlisle, Arkansas

Education:

University of Arkansas at Little Rock
Associate Degree in Nursing

Experience:

Administrator
Cabot Manor Nursing Home

Administrator
Lonoke Nursing Home

Director of Nursing
Lonoke Nursing Home

Staff Nurse
Memorial Hospital North Little Rock

Nurse Aide
Arkansas Children's Hospital

Organizations:

Arkansas State Board of Nursing

Arkansas League for Nursing

Arkansas Nursing Home Nurses Association

Diploma Nurses of Arkansas

National Association of Directors of Nursing Administration in Long Term Care

CURRICULUM COMMITTEE

BETTY NEWBY, RN - Committee Chairperson
Little Rock, Arkansas

Education:

Baptist System School of Nursing, Little Rock, Arkansas
Diploma Nurse

Experience:

Nursing Services Inspector
Arkansas Department of Health
Division of Health Facility Services

Nursing Services Inspector
Office of Long Term Care
Division of Economic and Medical Services
Arkansas Department of Human Services

Health Occupation Instructor/Coordinator
Metropolitan Vocational Technical Education Center
Little Rock School District
Little Rock, Arkansas

Weekend Registered Nurse Supervisor
Arkansas Nursing Home
Little Rock, Arkansas

Organizations:

American Association of Retired Persons

IDAVONNE ROSA, RN, LSW, ADM
Jonesboro, Arkansas

Education:

University of Central Arkansas, Conway, Arkansas

Experience:

Director In-Home Services
East Arkansas Area Agency on Aging
Jonesboro, Arkansas

Director of Nursing
Pioneer Nursing Home
Melbourne, Arkansas

Peace Corp
Kabul, Afghanistan

Administrator
Methodist Nursing Home
Fort Smith, Arkansas

Organizations:

President, Mid-America Congress on Aging

Advisory Committee for Continuing Education in Nursing
Arkansas State University
Jonesboro, Arkansas

Advisory Committee for Nursing
Delta Vocational Technical School
Marked Tree, Arkansas

Instructor - Continuing Education Program
Arkansas League for Nursing

CAROLYN SHANNON, MNSc, RNP, RN
Little Rock, Arkansas

Education:

University of Arkansas College of Nursing
Bachelor of Science in Nursing

University of Arkansas Medical Center
Pediatric Nurse Clinician Program - Certificate

University of Arkansas for Medical Sciences
Family Nurse Practitioner Program - Certificate

University of Arkansas for Medical Sciences
Master of Nursing Science

Experience:

Executive Director
Arkansas State Nurses' Association

Staff Nurse
University Hospital

Head Nurse
University Hospital

CURRICULUM COMMITTEE

Nurse Practitioner
    C & Y Project and Child Study Center

Instructor
    UAMS College of Medicine

Instructor
    UALR Department of Nursing

Assistant Professor
    UAMS College of Nursing

Organizations:

American Nurses Association

Arkansas State Nurses Association

Sigma Theta Tau International Honor Society for Nursing

UAMS College of Nursing Curriculum Committee

* * *

REVISION COMMITTEE JULY, 1992

This curriculum was revised in July, 1992 to encompass provisions of the federal regulations issued by the U.S. Department of Health and Human Services (Health Care Financing Administration). Other modifications were made based upon suggestions received from nursing facilities and training providers since implementing this program in July, 1989.

The revision committee included the following individuals:

Ruth Erlene Hamilton	(see previous committee listing)
Kay Hayes	RN, Office of Long Term Care
Peggy Moody	(see previous committee listing)
Idavonne Rosa	(see previous committee listing)
Thomas Wingard	Program Coordinator, Office of Long Term Care

ACKNOWLEDGEMENTS

Patricia Dismukes
Administrative Officer
Kansas Bureau of Adult and Child Care
Topeka, Kansas

Hillcrest Nursing Home, Harrison, Arkansas
Frederick Helmuth, Administrator
Elizabeth Yoder, Secretary
Melody Melmuth, S.P.N.

Baxter Manor Nursing Home, Mt. Home, Arkansas
W. Pat Flippo, Administrator

Cabot Manor Nursing Home, Cabot, Arkansas
Catlett Corporation
Sheila Martin, R.N., DON and Staff

Little Rock Nursing Center, Little Rock, Arkansas
J. T. Rose

East Arkansas Area Agency on Aging
Jonesboro, Arkansas

To those who wrote and/or came to committee meetings, sharing their knowledge and their experiences with their individual nursing assistant training programs.

To committee member's families who supported their hours of labor.

To our sister states who were so gracious to share their nursing assistant course materials.